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**Complementary and Alternative Medicine:
Nature, Origins, Ethics and Regulation**

Patricia Mary O'Rourke

**A Thesis
in
The Department
of
Religion**

**Presented in Partial Fulfilment of the Requirements
for the Degree of Doctor of Philosophy at
Concordia University
Montréal, Québec, Canada**

May 2001

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ABSTRACT

Complementary and Alternative Medicine: Nature, Origins, Ethics and Regulation

**Patricia Mary O'Rourke, Ph.D.
Concordia University, 2001**

Types of healing alternative to conventional medicine became increasingly popular in the latter quarter of the twentieth century and some physicians, hospitals and governments have begun to take the field seriously. While alternatives to whatever is considered to be conventional medicine have always existed, contemporary interest in complementary and alternative medicine (CAM) may be evidence of interest in unconventional forms of spirituality. Healing and religion have an ancient connection not often acknowledged by modern science. The attraction to medical alternatives may represent for some a deep need to find meaning and wholeness in suffering. Others, wishing to expand medical choice, may be drawn to alternatives that are more "medical" in type.

The journey towards health, particularly when spiritual in nature, is not without risk. The public has a right to be assured that publicly advertised healing methods are safe and their practitioners regulated and accountable. Unlike conventional medicine, alternative medicine in Canada is largely unregulated and some practitioners are inadequately trained and unaccountable to any official body. Given the increasing popularity and growing respectability of complementary and alternative medicine, it is important that Canadian society finds ways to regulate the field.

The first three sections examine the field of complementary and alternative medicine, bioethics, the relationship between religion and healing and the major philosophical and spiritual concepts in which different alternative healing methods are grounded. Section four takes an "ethics-led" approach to regulation (Stone and Matthews, 1996). It applies the four principles of autonomy, non-maleficence, beneficence and justice, first elucidated in the Belmont Report (1978), to complementary and alternative medicine to see if these ethical principles, taught widely in medical schools, form an adequate ethical framework for CAMs or whether CAMs have features that require additional principles.

The thesis concludes that while the four principles adequately encompass many of the ethical dilemmas presented in the practice of complementary and alternative medicine, a fifth principle, the fiduciary principle, is probably necessary to take into account the distinctively religious or spiritual aspects of many types of CAMs.

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**To the memory of my parents, Mary Josephine Condon O'Rourke, 1910-1999
and Francis O'Rourke, 1912-1973, who inspired in me a love of learning.**

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Part One

Ethical Issues in Complementary and Alternative Medicine

General Introduction

Complementary and Alternative Medicine and Biomedical Ethics

Biomedical ethics is a field that is only about thirty years old. While many theories and methods have been developed over this period of time, the system most familiar to doctors, because it is taught world wide in medical schools, is the four-principles theory first delineated in the Belmont Report (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, September 30, 1978). This thesis will take those four principles -- autonomy, non-maleficence, beneficence and justice -- and apply them to complementary and alternative medicine. The exercise will be an exploration of whether and where these principles can appropriately be applied to complementary and alternative medicine and a search for difficulties that may arise from the application of a system designed for biomedicine to this much more diverse field. Complementary and alternative medicine is a field with no or few ethical boundaries. As Julie Stone points out, it is rarely approached from an ethical perspective (1999, October, 425). Chapter two will present the main ethical issues which will be examined in depth in section four, chapters seven to eleven.

For most of the twentieth century, alternative medicine operated on the fringes of North American society. While homeopathy had always had privileged status in Great Britain's National Health system, and osteopathy, chiropractic and acupuncture came to be officially recognized in many provinces and states, other alternative practices were viewed with disfavour by the medical profession. Practitioners and clients of alternatives functioned in a medical underground. Towards the end of the century, some academic medical specialists

took a fresh look at the field: the U.S. National Institutes of Health created an Office of Alternative Medicine (1992) and by the mid 1990's, a number of academic books and serious journal articles on the subject had begun to appear. By late century, some argued that alternative medicine (now increasingly termed complementary and alternative medicine) had entered the mainstream. For example, in October 1998, a conference was held in Toronto, Ontario called *Complementary Medicine in the Mainstream*. A similar assumption lay behind the University of Pennsylvania Medical School's conference in November 1999 called *Complementary and Alternative Medicine in the Academic Medical Center: Issues in Ethics and Policy*. Academic interest in this field continues. The conference *Complementary Medicine 2001: From Evidence to Integration* (sponsored by The Ontario Society of Physicians for Complementary Medicine, The Complementary Medicine Section, Ontario Medical Association and the Department of Family and Community Medicine, The Faculty of Medicine, University of Toronto) was approved by the College of Family Physicians of Canada for continuing education credits.

When physicians became aware of public interest in complementary and alternative medicine, a number of surveys were conducted to assess the extent of the interest. The most important was the Eisenberg study published in 1993. This alarmed physicians into fearing that their patients were absconding to the competition (a particularly relevant issue in for-profit medicine). Yet extent of use can only be accurately measured when one is clear about what is and what is not included in the classification "complementary and alternative medicine" (which can be abbreviated to CAM). Although the thesis adheres to current practice, using the phrase "complementary and alternative medicine" as a single unit, "complementary" and "alternative" have very different meanings. Definitions and taxonomies will be presented in chapter three. Chapter four will look at the many reasons put forward for consumer interest in and use of complementary and alternative medicine.

Ayurvedic medicine and Traditional Chinese Medicine will be alluded to in discussions of complementary and alternative practices. However, a detailed discussion of these complex medical systems is beyond the scope of this thesis. Nor will the thesis do more than offer several brief acknowledgements of native North American healing. These three healing systems are embedded in rich and ancient traditions and deserve separate treatment by those well-versed in the relevant languages and cultures.

In Canada, complementary and alternative medicine has not entered the mainstream of medical practice but some therapies -- Therapeutic Touch and Reiki for example -- are practiced by nurses in oncology or palliative care wards with the approval of nursing departments and physicians and, in some cases, the provincial associations of nurses. A few hospitals have considered permitting some alternative practitioners to offer services to staff and patients on a fee-for-service basis. As hospitals contemplate inviting alternative medicine into its mainstream system of care, serious ethical issues arise: are the practices safe and efficacious and has this been proven through clinical trials? How should alternative practice be structured to make it accountable and how well-trained are the practitioners? While the thesis will examine the field of complementary and alternative medicine as practiced independently of hospitals, it cannot ignore the specific problems that can arise when complementary and alternative medicine is invited into the mainstream. Some of these issues may yield ethical models for the guidance of complementary and alternative medicine wherever it is practiced.

A central difficulty alluded to but not always addressed in depth in the medical literature on complementary and alternative medicine is its religious and spiritual¹ content. Although

¹In general, people give a wide range of meanings to the term "spirituality". I will, therefore, not attempt to define it.

some medical schools are attempting to bring religion back into medicine this is a re-marriage fraught with difficulties as the authors of articles in the *New England Journal of Medicine* (Sloan, et al., June 22, 2000, 1913-1916) and the *Hastings Center Report* (Cohen et al., May-June 2000, 40-47) point out. The spiritual aspects of healing may call for another type of ethical analysis.

The ethical dilemma arises because many practices of physical healing are grounded in or influenced by spiritual ideas. Therapeutic Touch, the channeling of healing spirits and Reiki are only three healing methods that draw on metaphysical and spiritual ideas. Any religious or spiritual practice that is effective has enormous power to influence the minds of its adherents. How can the doctrine of informed consent (which is related to autonomy, to be discussed in chapter seven) be applied to practices that may attenuate the free will of those drawn to them? What can one do to protect freedom of religion while at the same time making sure that the vulnerable do not get hurt? The religious and spiritual roots of complementary and alternative medicine will be explored in chapters five and six and in the conclusion.

The thesis will refer to but not dwell on frankly religious forms of healing. It is difficult to imagine a government wanting to control such spiritual practices as healing in Charismatic Renewal circles or healing shrines. Those who seek out these forms of healing are usually well aware of the religious and spiritual content of the rituals. Nonetheless, when religious healing is offered as a consumer good (Christian Science healers charge fees that can be reclaimed from some insurance companies), some might ask if it should be regulated along the same lines as secular complementary and alternative medical care. In some cases, spiritual healing includes the use of products that can harm. A young woman who participated in a Native sweat lodge advertised on the Internet says she suffered severe

headaches from inhaling the fumes of burnt herbs (personal communication, April, 2001).

Conventional medicine is a highly regulated system in which those who practice it are consistently trained and accountable and those who use its services have clearly defined courts of appeal if they are dissatisfied or injured. What it offers is increasingly evidence-based and scientifically tested. It functions within well-defined legal and ethical guidelines.

In contrast, the vast field of complementary and alternative medicine is largely unregulated and practiced by healers who may be well-trained and knowledgeable or untrained and dangerous. Many practitioners are accountable only to their own groups. They may display impressive diplomas granted by unregulated, unrecognized and unaccredited institutions. The products they offer may be benign but ineffective, or they may create serious health problems.

Safety, efficacy, accountability and training are important in conventional medicine but they are generally regulated by the government and by professional associations. Safety and efficacy will be discussed in chapter eight; accountability and training will be discussed in chapters nine and ten. Redress against those who harm will be discussed in chapter eleven under the heading adjudicatory or retributive justice, issues of equitable access to CAMs under distributive justice and the issues that arise from the relationship between practitioner and client under commutative justice.

* * *

All people need hope. Yet we live in a society marked by isolation, anomie and uncertainty. The world is disenchanted and our culture suffers a vacuum of meaning. What

complementary and alternative medicine frequently offer is re-enchantment and, therefore, hope and transcendence. Religion in its institutional forms is no longer relevant to many and modern medicine frequently ignores the human, holistic dimension of healing. Its scientific focus can lead patients to feel that objective measures are more valued by doctors than the emotional and spiritual component of illness. It is at this point that patients might leave the physician's office and turn to an alternative practitioner who has time to listen and to comfort a patient who may need tenderness after the rawness of an official medical encounter.

Many modern people are thus in flight from two orthodoxies -- conventional medicine and conventional religion. The guideposts familiar in the past are missing and we live in a deconstructed society in which some question the objective reality of what they observe. The purpose of this thesis is to see if the four-principles theory is sufficiently comprehensive to (1) provide a satisfactory ethical structure for the fluid and often vague field of complementary and alternative medicine and (2) supplement this theory, if necessary, with additional ethical guidelines so as to ensure the well-being of people at all levels -- physical, psychological, emotional and spiritual.

Chapter One

Introduction - Complementary and Alternative Medicine at the End of the Twentieth and the Beginning of the Twenty-First Century

The Popularity of Complementary and Alternative Medicine

Before the twentieth century, surgery was risky, anesthetics uncertain and pharmaceuticals more dangerous than the diseases they purported to cure. According to Roy Porter, writing about eighteenth century medicine, all evidence indicates that the medicine of the past -- before the discovery of the germ theory of disease, diagnostic technologies and the need for sterile operating theatres -- “was, and was perceived to be, at best only sporadically effective in meeting the threat of serious disease.” Consequently those with the money consulted regular physicians and a variety of alternative practitioners because their chances of cure were no more certain with one than with the other (Porter, 1988, 3-4).

Although serious infectious diseases remain a threat, the rise of modern scientific medicine has led to remarkable cures: severed nerves, as well as limbs, can be reattached and made functional; diabetics can live to old age; those with cardiac insufficiency can literally come back to life with someone else’s heart pumping the blood through their veins. There seems little reason to question the superiority of biomedicine.

But many do. Almost ninety years after the triumph of the American Medical Association in driving underground alternative forms of healing (the 1910 Flexner report, see below, was largely responsible for this), alternative medicine flourishes. Alternative practitioners abound in all major North American cities. Homeopaths, acupuncturists, iridologists, naturopaths,

reflexologists and other “holistic” practitioners offer to the general public ways of healing that purport to recognize the whole person and not just the part of the body that has malfunctioned. This is probably one secret to their appeal. As Fulder points out, this movement is not a fashion promoted by the media but a genuine grass-roots movement (Fulder, 1996, 35).

The biomedical approach is central to medical orthodoxy in North America and in Britain. Biomedicine evolved in the twentieth century to achieve almost perfect hegemony over the way in which health care is delivered. Since it achieved power as the dominant form of healing in the early part of this century, biomedicine has viewed with suspicion the claims of alternative medicine. Before 1910, many types of healing practitioners competed for patients. Medical training was not standardized. In the United States, in the 1880's, the Association of American Medical Colleges attempted to raise the standards of medical education. Allopaths (the homeopath's term for conventional doctors) and homeopaths had united against the newer practitioners -- chiropractors, osteopaths and Christian Scientists -- to prevent them from gaining such privileges as their own boards of medical examiners and control of licencing. In 1907 the Council on Medical Education went to the president of the Carnegie Foundation. The foundation hired Abraham Flexner to conduct a thorough investigation of all U.S. medical schools. His report, issued in 1910, led to the dominance of biomedicine in all medical training. Students, naturally wanting to be trained by the best, were drawn to the top medical schools. Weaker schools, including most homeopathic schools, were eventually eliminated by attrition. By 1935, the American Medical Association removed institutions of sectarian medicine such as homeopathic schools from its list of approved training institutions (Kaufman, 1988, 111-113). In Canada, the last homeopathic hospital in Montreal was the Queen Elizabeth Hospital, founded to practice this system of medicine. It ceased to offer homeopathic treatments in the 1950's (personal communication,

administrator, Queen Elizabeth Health Centre, July 2000).

In Great Britain, the National Health Insurance Act of 1911 (and, later, the National Health Service Act of 1946) gave practitioners of biomedicine a huge advantage over alternative medical practitioners because they were either employed by or approved by the state (Saks, 1992, 6). Therapies like homeopathy became seen as alternative medicine (Saks, 6-7) even though homeopathy has been part of the British National Health Insurance scheme since its 1946 inception.

Scientific medicine may have triumphed, yet, in spite of its apparent ascendancy, individuals have always resorted to what biomedicine views as fringe practices. Nowadays, this includes homeopathy, herbalism and various metaphysical healing modalities. The twentieth century began with biomedicine pushing alternative medicine to the fringes. In its closing years, some of these forms of medicine tiptoed back into the mainstream and some conventional practitioners evinced a cautious interest in what alternative medicine might offer the clients of biomedicine.

In 1984, the medical anthropologist Arthur Kleinman asked if the “current interest in holistic medicine and alternative healing systems... [represented] the last bright flicker of a candle about to go out, or represented a major reorientation of how health care will be delivered in our society...” (Kleinman, 1984, 156). Eight years later, the U.S. National Institutes of Health created an Office of Alternative Medicine and many medical licencing bodies, medical schools and hospitals, secure in their prestige, began to show interest in biomedicine’s alternatives. In 1998, the Office of Alternative Medicine was re-established by U.S. Congress as the National Center for Complementary and Alternative Medicine.

It may be too soon to state that alternative medicine will lead to “a major reorientation of how health care will be delivered,” but time has shown that it is not “the last bright flicker of a candle about to go out...” (Kleinman, 1984, 156). Some suggested that, by the year 2000, alternative medicine might assume either a “barefoot doctor” role in a bare-bones health care economy or, if prosperity were achieved, join conventional medicine as a type of total wellness resource (West, 1984/1992, 210). The latter, in fact, appears slowly to be happening. Alternative medicine, re-named complementary medicine when it is invited into the conventional setting, or used with conventional medicine, is now the object of serious study. A conference, *Complementary Medicine in the Mainstream*, held in Toronto, Ontario, in November 1998, gathered pharmaceutical companies, respected directors of alternative medical schools and government and insurance company executives to study the challenges of this new development. The conference was organized by *Insight Information Co.* and its media sponsor was *The Globe and Mail Report on Business*. Not surprisingly, given the business orientation of the conference, much attention was paid to the market for herbal remedies. By the end of the twentieth century, the use of alternative medicine was not as widespread as Fulder had suggested but the keen interest of pharmaceutical and insurance companies in alternative medicine signalled the conversion of some forms of alternative medicine into a lucrative complementary medicine market. Now ethicists are taking notice. In November 1999, the University of Pennsylvania School of Medicine, along with the NIH National Center for Complementary and Alternative Medicine, sponsored a conference: *Complementary and Alternative Therapies in the Academic Medical Center: Issues in Ethics and Policy*. The program faculty included such important figures in the field of ethics as Howard Brody and Arthur L. Caplan.

Alternative medicine is big business. A much-referred-to- study published in the *New England Journal of Medicine*, revealed that in 1990, 34% (out of a total of 1539 people over

the age of 18 interviewed by telephone) of Americans used at least one unconventional therapy in the twelve months preceding the interview (Eisenberg et al., 1993, 246). Those with higher incomes and more education patronized practitioners of alternative medicine. This study was repeated, with some alterations, to see what had changed between 1990 and 1997.² The researchers revealed that in the 12 months preceding 1997, the number of Americans using one of 16 alternative therapies was 42.1%. Those with the highest incomes and education were, again, the most numerous users (they may also be the most likely to participate in studies). These figures, extrapolated to the American population, suggest, according to Eisenberg, an increase of 47.3% from 1990 of the number of appointments made with alternative practitioners. This is higher than the total number of conventional medical appointments (Eisenberg et al., 1998, 1569). These studies are, however, based on questions about therapies that not everyone would consider alternative. As the study authors point out, therapies such as diet or vitamin therapy might fall at the conventional end of the spectrum (Eisenberg, et al., 1998, 1574). As in the 1990 study, what the authors call “self-prayer” (as opposed to spiritual or energy healing) was investigated to see how commonly people prayed for healing but the data was analyzed only to see how commonly it was used (Eisenberg et al., 1998, 1571).³

The later Eisenberg study points to two very significant changes from 1990 -- a 380%

²The 1997 survey covered all questions asked in the study published in 1993 and added in-depth questions for those who used more than three alternative therapies (Eisenberg et al., November 11, 1998, 1570-1571).

³The Eisenberg study looked at the following alternative practices: relaxation techniques, chiropractic, massage, imagery, spiritual healing, commercial weight-loss programs, lifestyle diets such as macrobiotics, herbal medicine, megavitamin therapy, self-help groups, energy healing, biofeedback, hypnosis, homeopathy, acupuncture, folk remedies, exercise, prayer. The Canadian National Population Health Survey of 1996-1997 included massage, naturopathy, homeopathy, acupuncture, herbalism, reflexology, relaxation therapies, spiritual healing (Statistical Report on the Health of Canadians, 1999, 147).

increase in the use of herbal medicine and a 130% increase in the use of high-dose vitamins. In 1990 2.5 % of those surveyed said they had used herbal medicines in the past 12 months. In 1997, the figure was 12.1%. 2.4% had used megavitamins in 1990; 5.5 % in 1997. Forty-four percent of adults who used prescription medications also used herbal preparations and vitamins along with prescription medications but they did not tell their doctors. The study authors extrapolate from the total American population to suggest that about 15 million adults have, in this way, put themselves at risk (Eisenberg et al., 1998, 1569-5).

In Québec, the Ministry of Health in 1990 said that 33% of Québeckers used alternative medicine. In 1990 the Québec Ministry of Health proposed a discussion of criteria for recognizing alternative therapies and evaluating and accrediting the practitioners (*Reform of the Health and Social Services Network*, 1990, December 7, 28-29). To date, this has not occurred.

In Canada, in 1996-1997, seven percent of Canadians over the age of 12 reported that they used alternative health care in the previous 12 months as compared to five percent in 1994-1995. This official government survey interviewed 82,000 people over the age of 12 (Statistics Canada, Statistical Report on the Health of Canadians, 1999, 147-148). In August, 1997 CTV/ Angus Reid conducted a survey of 1,200 Canadians over the age of 18 about their use of alternative therapies within the past 12 months. It found that 42% of Canadians used alternative medicine. Of the 42%, 49% were between the ages of 35 and 54 and 52% earned more than \$60,000 a year. 55% said that they had used an alternative form of medicine for more than five years. Chiropractic was the most popular method followed by herbology, acupuncture and homeopathy. Massage therapy, aromatherapy, reflexology, hypnosis, vitamin therapy, health food, energy healing, reiki, yoga, Native American

medicine, osteopathy and physiotherapy⁴ were also used

(<http://www.angusreid.com/old/pressrel/alternat.htm>).

48% said they used alternative medicine because they believed it was harmless and possibly helpful; 34% said they used it because regular medicine did not work for them; 33% used alternative medicine because they thought it to be more natural; 23% worried about the dangers of conventional drugs and treatments; 17% thought alternative practitioners provided better service. Only 6% said they used alternative medicine because they did not trust conventional medicine (<http://www.angusreid.com/old/pressrel/alternat.htm>).

Many surveys of complementary and alternative medicine, such as the Eisenberg study, include self-prayer for healing as an alternative medical technique. One could argue against including prayer in these surveys for two reasons: far more people are likely, at some time in their lives, to ask God to heal than they are to consult homeopaths or use energy healing. Consequently the statistics on the use of alternative medicine may therefore be unnaturally high. It also seems somewhat arrogant for the medical establishment to put prayer on the same footing as a conventional or alternative medical technique although studies conducted in the 1980's and 1990's have attempted to prove that prayer "works" as a medical technique (see Byrd, 1988; Harris et al., 1999; Dossey, 2000).

Physician Attitudes to Complementary and Alternative Medicine

In a move significant to the growing respectability of alternative medicine, the prestigious *Journal of the American Medical Association*, and associated American Medical

⁴It is not clear why Angus Reid accepted physiotherapy as a type of alternative medicine when it has been practiced as an adjunct to conventional therapy for approximately 50 years.

Association specialty journals, devoted their November 1998 issues to alternative medicine, publishing more than eighty articles. Article topics ranged from reports of surveys, discussions of ethics and risk management, results of specific studies and opinion pieces. A senior editor of *JAMA*, Dr. Phil B. Fontanarosa, forcefully stated his opinion that the only acceptable alternative medicine is that which is proven by science:

There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data or unproven medicine, for which scientific evidence is lacking. Whether a therapeutic practice is "Eastern" or "Western", is unconventional or mainstream, or involves mind-body techniques or molecular genetics is largely irrelevant except for historical purposes and cultural interest. We recognize that there are vastly different types of practitioners and proponents of the various forms of alternative medicine and conventional medicine, and that there are vast differences in the skills, capabilities, and beliefs of individuals within them and the nature of their actual practices. ... Nonetheless, as believers in science and evidence, we must focus on fundamental issues -- namely, the patient, the target disease or condition, the proposed or practiced treatment, and the need for convincing data on safety and therapeutic efficacy (Fontanarosa, 1998, 1618).

Dr. Fontanarosa presents belief in science and evidence as a self-evident truth. Not all would agree. In the same issue of the *Journal of the American Medical Association*, Daniel P. Eskinazi, from the Rosenthal Center for Complementary and Alternative Medicine, Columbia University College of Physicians and Surgeons, New York, offered another perspective: Biomedicine, he points out, "is founded in part on materialism" which views matter and biological processes as the only reality. "Materialism," he says, "therefore, is akin to a religion, ie, 'a system of beliefs held to with ardor and faith'" (citing Merriam-Webster's Collegiate Dictionary, 10th ed., 1993, Eskinazi, 1998, 1623). An article in the *Annals of Internal Medicine* by Frank Davidoff, MD, referred to the popular interest in alternative medicine as "baffling and disturbing":

Our distress echoes the feelings of parents whose children reject their advice and values: How can it be that alternative practices, shrouded in mystery, grow and flourish, while a century and half of effort by scientific medicine to demystify disease and its treatment -- our spectacular success in defining pathophysiology, standardizing tests and treatments, and purifying drugs -- is seen as inadequate, even dangerous? Where did we go wrong? (Davidoff, 1998, 15 Dec, 1068).

Dr. Davidoff's plaintive question betrays a paternalism of which he, comparing patients to children, seems to be aware. He points out that scientific medicine's self-scrutiny is one of its most important achievements. Unfortunately, such rigorous honesty may lead to loss of confidence in conventional treatments known for their "inefficiencies and...dangers" whereas "alternative medicine generally takes the position that the efficacy of its therapies is intrinsically unmeasurable because therapy for every individual patient is, by definition, unique..." Hence, he says, alternative medicine is seen to be "kinder, gentler, safer..." (Davidoff, 1998, 1069). He concludes that interest in alternative medicine is a cry for help from patients who may feel they do not receive sufficient time or information from their physicians (Davidoff, 1070). His position is common among physicians who often believe that patients are turning to alternatives out of dissatisfaction with conventional physicians and their treatments. This is not necessarily the case, as chapter four will suggest.

Physicians often tend to view those who seek out alternative medicine as gullible and desperate. A pamphlet issued to the public by the Investigation Department of the Collège des médecins du Québec in 1996 recommends that people planning to use an "unapproved and unproven" therapy first consult, among others, the Office des professions du Québec or Health Canada. While rightly recognizing the vulnerability of patients with serious illness, they seem to exaggerate the power of illness to rob normally sensible people of good judgement. Consider the following:

Parading under the banner of hope and the "promise of a cure" many "modern healers" are attracting a host of people grappling with health problems. Certain misinformed and sometimes highly vulnerable individuals are being out and out deceived by unscrupulous opportunists. Some are even seeing their health problem get worse. Indeed, cases of this kind are often reported to the Investigation Department of the Collège des médecins, or to other agencies.

Sick persons may also be influenced by an acquaintance, a relative or a friend... (Collège des médecins, Investigation Department, 1996).

Some doctors have become ecumenical in their approach to healing and have turned to alternative medicine to see if it can find answers to intriguing medical problems. In 1992, when the U.S. National Institutes of Health created the Office of Alternative Medicine, it planned to research the merits of therapies outside the mainstream of conventional healing. Biomedical researchers hoped to find new approaches to chronic diseases like cancer and AIDS and to autoimmune diseases for which conventional medicine often has no remedy (Crigger, May/June 1993, 2; Unconventional therapies vie for professional acceptance, May/June 1993, 6; Mind and body medicine: a new paradigm, 1993, Feb 20, 66, 68).

A survey published in the *Canadian Family Physician* stated that 56% of Ontario and Alberta general practitioners believe alternative medicine can offer useful ideas to conventional medicine (Verhoef and Sutherland, 1995, June, 1005). In Montreal, in 1994, the Medical- Chirurgical Society offered an evening for physicians (organized by the author) on alternative medicine because, as the sponsoring hospital's medical organizer said: "we need to know what our patients are interested in." In 1994 the Medical Society of Nova Scotia asked for official recognition of alternative medicine and in May of that year it created a section for physicians who practice complementary medicine. In 1996 an institute of alternative medicine (Tzu Chi Institute for Complementary and Alternative Medicine) opened at Vancouver Hospital and Health Sciences Centre. It sponsors and conducts research into Chinese, Ayurvedic, native Amerindian treatments and other alternative treatments. The centre is partly funded by the Buddhist Compassion Relief Tzu Chi Foundation. At the Canadian Medical Association's annual meeting in 1996, a three- hour symposium on alternative health care drew a standing-room-only crowd of 300 people according to the *Journal of the Canadian Medical Association* (Sullivan, 1996, Nov 1, 1330). Canadian oncologist Dr. Robert Buckman, who was the keynote speaker, said that at least 80% of cancer patients use some form of alternative therapy. In October 1999,

Canadian family physicians attended a workshop, accredited by the Canadian College of Family Physicians, on alternative medicine. The workshops, held across Canada, were sponsored by *Review of Alternative Medicine*. The invitation stated “over 80% of patients toy with alternative medicine. Over 65% of physicians don’t know how to answer their patients’ alternative medicine questions. And barely 10% of physicians feel they’ve mastered even one area of alternative medicine (letter from conference organizer, August 30, 1999). The use of the verb “toy” both demeans popular interest while implying that public attraction to alternative medicine is not too serious. Neither *Review of Alternative Medicine*, nor the speaker of the day, had positive views of medical alternatives. Much time was devoted to the false claims of alternative medicine. Nonetheless, the fact that workshops like this were held across the country indicates a sudden interest in a topic once considered beneath consideration.

What accounts for this sudden burgeoning interest? As noted above, some physicians hope to find in alternative medicine answers to problems that have eluded conventional medical science: cures for cancer and for antibiotic-resistant infections. They also recognize that alternative practitioners may be more attentive listeners, spend more time reassuring the patient, and give clearer explanations of illness than is possible in a busy hospital clinic (see Buckman, 1993). Those who are familiar with alternative medicine may consider prescribing it for certain chronic illnesses such as arthritis or asthma. The survey published in the *Canadian Family Physician* revealed that 54% of Canadian general practitioners refer patients to practitioners of alternative medicine and 16% practice some form of alternative as well as conventional medicine (Verhoef and Sutherland, 1995, June, 1005). In a 1997 survey, conducted by Verhoef and Page, primary care physicians found diet and nutrition, mind-body therapies, bioelectromagnetics, traditional and folk remedies, pharmacological and biological treatments and manual healing to be helpful to patients. Most referred

patients to practitioners of manual or traditional healing methods (Verhoef, paper *Complementary Medicine: Impact on Physicians*, 3-5, presented to conference: *Complementary Medicine in the Mainstream*, Toronto, Ont., November 23, 1998).

Attitude of Medical Societies and Licencing Groups

Lawyer Karen Capen has discussed the growing interest of medical societies, courts and licencing bodies in developing guidelines to deal with alternative medicine. Two provincial licencing/regulatory colleges reveal two very different approaches she says. The first, the College of Physicians of British Columbia, takes the traditional approach. This group's policy about "unproven and unconventional treatment" strives to maintain the standards of conventional medicine. Their policy says: "it is unethical to engage or to aid and abet in treatment that has no acceptable scientific basis, may be dangerous, may deceive the patient by giving false hope, or that may cause the patient to delay in seeking proper care until his or her condition is irreversible" (Capen, 1997, May 1, 1308). However, in Ontario, the College of Physicians and Surgeons took a slightly more open approach. In 1996 it established a committee to examine its position on alternative medicine, the mandate of which was to recommend "core values" governing its use. It also planned to make recommendations about when members should be allowed to use unvalidated diagnostic methods and when they would be allowed to offer patients unproven alternative health therapies. Its last responsibility was to present requirements that physicians must fulfill when patients who refuse conventional diagnosis ask for an alternative therapy (Capen, 1997, May 1; The College of Physicians and Surgeons of Ontario, 1997, September 22, [http:// www.cpso.on.ca](http://www.cpso.on.ca)). Its September 22, 1997 report evinced a respect not always found in the deliberations of conventional physicians. It recommended that standards for physician performance in the area of complementary medicine be set by standing advisory panels that include respected complementary medical practitioners. Under the heading "Education",

the news release said:

Many unconventional or complementary disciplines of healing have established a historical and respected role in healing, and require arduous training and evaluation in these areas. Assuming that they have obtained such training and expertise in non-traditional fields (e.g. acupuncture, naturopathy, homeopathy, traditional Chinese medicine, and chiropractic) physicians practising in this area should regard and maintain the standards of those disciplines (The College of Physicians and Surgeons of Ontario, 1997, September 22, [http:// www.cpso.on.ca](http://www.cpso.on.ca)).

Marja Verhoef, in a paper delivered to the 1998 conference *Complementary Medicine in the Mainstream*, says that the provincial colleges of physicians and surgeons offer limited guidance. Guidelines could be written not only to help physicians whose patients ask for alternative therapies but to guide physicians who practice some form of alternative medicine themselves (a number of homeopaths are medical doctors, for example). In a national survey conducted by Prof. Verhoef and her team of researchers in 1992, Prof. Verhoef found that 22% of physicians said they practiced such forms of complementary medicine as mind-body therapies, manual healing and diet and nutritional treatments. Yet in 1998, only five of ten provinces (BC, AB, SK, MB, PQ) had issued formal statements about conventional physicians practicing alternative medicine. Four created general policies and one, Saskatchewan, appeared at that time to be developing specific guidelines for selected therapies. Ontario and Newfoundland were working on policy guidelines. New Brunswick, Nova Scotia and Prince Edward Island had, at that date, “nothing specific” in place (Verhoef, 1998, paper *Complementary Medicine: Impact on Physicians* presented to conference: *Complementary Medicine in the Mainstream*, Toronto, Ont., November 23, 1998, 6).

Details in each of the four general policy statements that do exist vary greatly. All say that “scientifically recognized” treatment must be offered first. However, they differ in what they say about diagnostic methods, standards of physician education, proof of the efficacy

of the therapy and how to handle informed consent and the keeping of records. They also offer little to help the physician who wants to refer his or her patient to a complementary practitioner. Without these policies, Verhoef points out, physicians place themselves in danger when making referrals to alternative practitioners: they could be accused of professional misconduct; they may place patients at risk. This problem is heightened by the fact that, with the exception of the complementary disciplines, such as chiropractic or acupuncture, which have their own licencing groups and accredited education, most alternative practices are unregulated and inconsistent in the type of care they offer and in the quality of their practitioners. This makes it difficult for doctors to feel comfortable about making referrals (Verhoef, 1998, paper *Complementary Medicine: Impact on Physicians*, 6-7, presented to conference: *Complementary Medicine in the Mainstream*, Toronto, Ont., November 23, 1998).

Government Interest

In Canada, pharmaceutical products and medical devices are governed by Federal regulations. After a sometimes acrimonious debate with the public about the licencing of herbal products, the Health Protection Branch of the Federal government created a division to study these products separately from conventional pharmaceutical products. No Federal guidelines exist to govern alternative practices or practitioners as this is a provincial matter. However, on May 2, 2000, the *National Post* reported that federal health minister Allan Rock had asked the Liberal government for \$100 million so that acupuncture, chiropractic and traditional medicine could be insured by Medicare in Ontario (Harris, 2000, May 2, A8). An Angus Reid poll, however, revealed that the majority of Canadians surveyed rejected this idea because therapies are unproven (Aubry, 2000, August 8, A7).

In the U.S., the most significant evidence of interest in alternative medicine was the establishment, as noted before, of the Office of Alternative Medicine at the U.S. National Institutes of Health. Canadian researchers have access to this funding. While some feared that the NIH OAM would, according to Tim Beardsley, “divert resources from more productive lines of research and lend an appearance of legitimacy to quackery and fraud” (Beardsley, 1993, September 3), the research grants available through this office make it possible for researchers to study the claims of alternative medicine. Since its inception, research funded by the Office of Alternative Medicine has moved beyond exploration to producing evidence. By the end of 1998, it had funded 13 research centres at universities and other U.S. institutions⁵. Its large clinical trials make it possible for researchers to be trained in alternative medicine research (Marwick, 1998, Nov 11, 1553). The issue of effective research in alternative medicine will be discussed in chapter eight. In addition, fifty U.S. medical schools now teach courses on the place of religion and prayer in healing (Dossey, 1999, 199).

⁵Centres affiliated with the National Center for Complementary and Alternative Medicine are: **Bastyr University**, Bethel, Washington, Bastyr University AIDS Research Center; **Columbia University**, New York, Centre for Complementary and Alternative Medicine; **Harvard Medical School**, **Beth Israel Hospital**, **Deaconess Medical Centre**, Boston, Centre for Alternative Medicine Research; **Kessler Institute for Rehabilitation**, West Orange, NJ, Center for Research in Complementary and Alternative Medicine for Stroke and Neurological Disorders; **Palmer Center for Chiropractic Research**, Davenport, Iowa, Consortial Center for Chiropractic Research; **Stanford University**, Palo Alto, Calif., Complementary and Alternative Medicine Program at Stanford; **University of Arizona Health Sciences Center**, Tucson, Program in Integrative Medicine; **University of California, Davis**, Davis, Calif, Center for Alternative Medicine Research in Asthma and Immunology; **University of Maryland School of Medicine**, Baltimore, Center for Alternative Medicine, Pain Research and Evaluation; **University of Michigan**, Ann Arbor, University of Michigan Complementary and Alternative Medicine Research, Center for Cardiovascular Diseases; **University of Minnesota Medical School**, Minneapolis, Center for Addiction and Alternative Medicine Research; **University of Texas Health Science Center**, Houston, University of Texas Center for Alternative Medicine; **University of Virginia**, Charlottesville, University of Virginia Center for the Study of Complementary and Alternative Therapies (from JAMA, 1998, Nov 11, 1553).

Some recently tested therapies, reported in the Nov 11, 1998 issue of the *Journal of the American Medical Association (JAMA)* November 1998, include Chinese herbs for irritable bowel syndrome, saw palmetto for benign prostatic hyperplasia and yoga for carpal tunnel syndrome. In 1999, the U.S. Congress increased the budget for research into alternatives from \$20 million to \$50 million.

Involvement of Universities and Medical Schools

As revealed in the footnote to the section above, reputable American medical schools are taking alternative medicine seriously enough to teach it and to do alternative medical research. In Canada, the topic of alternative medicine might be introduced in a general course — for example in a course offered by McGill University's *Social Studies of Medicine*, but actual training is confined to CEGEPs (Collège d'enseignement général et professionnel) and community colleges. Marja Verhoef, a professor at the University of Calgary, strongly recommends physician education in this field, both general and specific. She even suggests that those who wish to practice complementary medicine be educated and evaluated to the level of dual registration (Verhoef, 1998, 8). Given the huge numbers of people who use alternative medicine but who do not, or cannot, discuss this with their doctors, physician education is enormously important. One difficulty faced by patients is that they often know more about this topic than their doctors. Marja Verhoef recommends that a resource centre be created to help both consumers and clinicians (Verhoef, 8).

Federal health minister Allan Rock, according to a news report, is planning to make provision for an Institute of Comprehensive Medicine at McMaster University Faculty of Health Sciences, Hamilton, Ontario. It will be the first formal link between the Canadian College of Naturopathic Medicine and a university (Harris, 2000, May 2, A8).

In the UK, Edzard Ernst, MD., PhD holds the chair in complementary medicine, at the University of Exeter. It was established in 1993, funded by the Laing Foundation. The Department of Complementary Medicine, of which Professor Ernst is head, was founded to conduct inter-disciplinary research and promote analytical thought about complementary medicine (University of Exeter, <http://www.internethealthlibrary.com>). Many other U.K. universities also offer education in complementary and alternative medicine -- both theoretical and practical.

Hospital Involvement

Hospitals of the future may well have, alongside medical wards, surgical wards, obstetrics and gynecology wards, paediatric wards and psychiatric wards, an alternative medicine ward. What is more likely, however, is that alternative medicine will offer services to all the wards, functioning as a consult service. This is the model used by palliative care services.

Alternative medical services are already offered in some Canadian hospitals (see York University Centre for Health Studies, August, 1999, 74-78), most notably in palliative care units (Conference: *Complementary and Alternative (CAT) Therapies in End-of-Life Care for Seniors*, University of Ottawa Palliative Care Service, Toronto, Ontario, Feb 24, 2000).

At the November 1998 conference *Complementary Medicine in the Mainstream*, participants from some Toronto hospitals said that their hospitals were in the very early stages of meeting with alternative practitioners to see how their services could be offered within the hospital. They were inspired by the requests of their patients (personal communication, conference attendees, November 23, 1998).

One Canadian hospital created a committee to look specifically at alternative medicine (the hospital already has a Therapeutic Touch clinic). It did so under pressure from patients,

clients and others who wanted more complementary medical modalities added to its services. The committee disbanded over what the coordinator says was a power struggle. The hospital wanted to offer complementary medical services through a non-profit organization that it would own. It thought this organization should be guided by a board of directors composed equally of hospital and complementary medicine representatives. The complementary medicine community felt the hospital was trying to take too much control and this became a stumbling block (personal communication, coordinator, December, 1998). A hospital in Western Canada found the issues of proof of efficacy and informed consent to be stumbling blocks. The hospital had difficulty with the fact that it is difficult to give patients information about alternative medicine's efficacy and side-effects where no standard clinical information exists. This hospital also says that it had issues about the implicit accreditation that would occur through granting alternative medical practitioners status in the Institute (personal communication, member of ethics service, Nov 1, 1997).

An article in the *Canadian Medical Association Journal* reported that Toronto East General Hospital already had a Therapeutic Touch clinic and planned to open several more clinics for complementary and alternative treatment. It added that some practitioners would be independent whereas others would be paid by the hospital and receive referrals from physicians. A goal was to have general practitioners' offices located next to alternative medicine clinics so that they could work together (Elash, 1997; Dec. 1: 1589-92).

A study prepared for Health Canada by York University Centre for Health Studies describes about 50 nurses trained in Therapeutic Touch who offer it at Sunnybrook and Women's College Health Science Centre in Toronto. When the hospital decided to focus on "patient centred care" it saw an opportunity for patients to make up their own minds about complementary care. However, problems stemmed from this decision. They were

described as “the question of legal responsibility for unproven methods of treatment...the allocation of scarce resources, and the question of patient demands conflicting with professional judgments.” Research is needed according to those involved (York University, 1999, 199).

Back in 1997, the President’s Council of Sunnybrook Health Sciences Centre had been putting the finishing touches on a policy that would have allowed professional and ancillary health care staff, as well as volunteers, to include such techniques as iridology or aromatherapy as part of patient care. ⁶ The Vice President of Professional Affairs was quoted as saying that the hospital could not deny access to these therapies if it claimed to believe in patient autonomy. Ethicist Eric Meslin, a former staff bioethicist there, objected, saying “Personal autonomy is not an endless request for whatever one wants.” He added that hospitals need to set limits on what they offer (Elash, 1997, Dec. 1: 1589-1592). Dr. Paul C.S. Hoaken commented in a subsequent issue of the *Canadian Medical Association Journal* that it is nonsense to say that if alternative therapies are not offered in hospitals then hospitals are denying access. “What we are doing by making them available in hospitals is lending them an aura of scientific respectability” (Hoaken, 1998, May 19, 1270-1271). Some have seen official U.S. government funding of research into alternative medicine as a response to popular demand rather than motivated by scientific curiosity. Tom Delbanco, MD describes, in an article in *JAMA*, the bench scientist who “recently asked a speaker discussing research in alternative medicine at our Medicine Grand Rounds, ‘Why don’t we

⁶One of the authors of the report from York University Centre for Health Studies said that when the surveyors interviewed an organization at the national level, the surveyors were told that the policy had been written. However, when they phoned the Office of Natural Health Products and the Vice President of Professional Affairs at the hospital, they were told that the policy had come about when the hospital amalgamated with Women’s College Hospital, that it had made its way through various committees, and was then abandoned (York University Centre for Health Studies, 1999, 78).

form a center at Harvard for the scientific study of astrology? After all, it's far more popular than homeopathy and massage therapy!'" (Delbanco, 1998, November 11, 1561). As Delbanco suggested, money should not be wasted, whether tax dollars or donations, on studies of products and methods that have no intrinsic value and flourish only because of popular demand. He uses homeopathy as an example (Delbanco, 1998, November 11, 1561). However, the whole point of the NIH office was to fund research to find out if certain methods were effective, so this is something of a circular argument.

The issue of complementary medicine offered alongside orthodox care in conventional hospitals raises serious ethical issues that will be discussed throughout this thesis. Medical and nursing boards within hospitals are responsible for the medical and nursing acts that take place on their institutions' premises. If alternative medical care is offered by a group independent of the medical staff, as a type of "add-on" service administered on the same basis as the gift shop or hair salon, then it demeans alternative practice, may lend some practices a spurious legitimacy and get the hospital into serious trouble if patient care is compromised. Patients (including staff who use its services) will not make the fine distinctions between hospital-administered and community-board administered programs if they are dissatisfied, feel they did not give informed consent or believe themselves to have been injured, physically, psychologically or spiritually. A particular problem will arise with practices that are considered spiritual as well as medical. For example, Therapeutic Touch is viewed as effective by its practitioners and devotees and harmless by those unconvinced of its therapeutic power. But it might be seen as a spiritual practice because its theoretical basis is that the body contains invisible energies that need to be re-balanced. This may seem innocent enough, but patients ought to be given full information about the beliefs in which a practice is grounded. The pastoral service staff of the hospital should be involved in these discussions, as well as the Clinical Ethics committee.

Further problems arise when the doctors on staff have no evidence on which to recommend an alternative practice. At the November 1998 conference on alternative medicine (*Complementary Medicine in the Mainstream*), a recurring theme in discussions was the difficulty a physician or pharmacist faces when asked to refer a patient or prescribe for or sell to him or her a substance for which no evidence of efficacy exists. Another problem faced by hospitals offering alternative medicine is the regulation of its practitioners. If the hospital is accountable for all who practice within its walls, how will it accommodate alternative practitioners if no national, agreed-upon standards exist?

Hospitals should be wary of reacting to the growing interest in alternative medicine by offering complementary and alternative medicine in response to popular demand. One suspects that some hospitals, in an attempt to appear "cutting edge" see alternative medicine as a "value-added" extra, like a garden for patients or a lecture program. This fails to take the field seriously. On the other hand, hospitals should be aware of patients' growing interest in alternatives. Its staff could usefully be involved in research and education so that patients are informed when they go *outside* the hospital for complementary care. It is questionable whether hospitals should offer complementary and alternative care. While they might offer tried and proven modalities, perhaps chiropractic, or help patients with such relatively innocuous treatments as aromatherapy, they should, perhaps, leave alternative medicine to the private sector. Some alternative practitioners may be flattered when invited to join the respectable ranks of conventional health care. While this implicit accreditation might encourage some otherwise skeptical clients to consult them, others might abandon them for "selling out". Alternative medicine, when coopted by the mainstream, may lose some of its appeal. The mainstream may wish to include it in its armamentarium of healing nostrums so as to control it. Paul Root Wolpe, of the Department

of Psychiatry and the Department of Sociology of the University of Pennsylvania, sees this as the maintenance of professional authority. He argues that medical reorganization at the end of the twentieth century is remarkably like that at the end of the nineteenth. The nineteenth century establishment, he said, finally stopped fighting homeopathy and invited homeopaths to become licenced and to join with conventional physicians. Eventually, the separate homeopathic schools shut down. He sees the same colonizing mentality at work today (Wolpe, personal communication, June 28, 1999). Mainstream medicine will never eliminate alternatives, however. If this were to happen, it is likely that alternatives to the alternatives would evolve.

One cannot deny that the public is greatly interested in alternatives to conventional care and might welcome physicians who can help them to understand and choose from among the array of treatments available. Tom Delbanco offers a note of caution. He sees alternative therapies, which appeal to the human need for hope and mystery (as opposed to the focus of scientific medicine on dysfunction) as enduring. However, he says, "the current explosion in alternative medicine is rooted differently. Signs of this fact are plentiful: ...media hype drowns out the negatives; and patients spend money that might better go elsewhere." He believes that alternative medicine will have a positive effect on conventional medicine but predicts that the huge numbers of people interested in it will "diminish with time, leaving a core of true believers similar to those of the past" (Delbanco, 1998, 1561-1562).

This chapter will conclude with a short discussion of some frequently asked questions: (1) How is alternative medicine connected to religion and spirituality and why is it so popular in a scientific age? (2) If the values held by alternative medicine are so different from conventional medicine, is there is there a way to overcome difficulties posed by what is termed incompatible discourse?

Alternative Medicine and Religion in a Scientific Age

Many people see alternative medicine as a belief system and conventional medicine as objective science. Alternative medicine is seen by some biomedical practitioners as non-rational, non-technical, non-scientific. Some view the increased professional and popular interest in alternative medicine as proof that biomedicine, with its Cartesian dualism, has alienated patients from their lived experience of illness. One can scarcely miss the gloating tone of some of the anti-medical literature.⁷ Biomedicine, the proponents of alternative medicine say, treats the body like a machine whereas alternative medicine treats the whole person. Some of the attraction of alternative medicine, particularly herbal medicine, lies in a fear of, and lack of confidence in, conventional drug therapy. It seemed, in the first half of

⁷In spite of alternative medicine's proponents' sometimes obsessive concern with conventional medicine's supposed mechanical approach to healing, Christopher Lawrence and George Weisz point out that, though nineteenth century physicians may not have acknowledged it, their approach was traditionally holistic. Some twentieth century physicians in the years 1918 to 1939, by recognizing traditional ideas, believed in holism, an idea which values the innate healing power of the body. These physicians are part of a continuing tradition that works with the body rather than attempting to conquer it (Lawrence and Weisz, 1998, 2-5). A 1998 article in the *Journal of the American Medical Association* claims that the fundamental "health-related goals" of alternative and conventional medicine are very similar. Physicians Sugarman and Burk cite Bratman saying that alternative and conventional doctors believe in the "(1) Use of natural remedies rather than artificial drugs, (2) Getting to the root of problems rather than treating symptoms..., (3) Treating the person instead of attacking the disease, and (4) Preventing illness rather than treating it after the fact, and promoting wellness rather than the mere absence of disease" (Sugarman and Burk, 1998, 1624). Conventional physicians may hold such idealistic views; practice frequently falls short. The demands of a busy practice, particularly if hospital-based, leave many physicians with time only to perform essential tasks. The patient weeping because the physician has told her she is ready to go home because "no pathology could be found" (my quotes) may well find a psychiatrist by her bedside as a response to an emotional "symptom". This is a problem engendered by the way in which physicians and surgeons are trained. The human person is divided into discrete entities like the diagrams of the cow one sees at butchers' counters. Thus we have lung specialists who need to call in the orthopedic surgeon to examine the back; the gastroenterologist who must call in the gynecologist for abdominal pain with its source in female reproductive organs. The physician who sees his or her patient in such a segmented manner may see emotional symptoms as the province of the psychiatrist.

the twentieth century, that pharmaceutical discoveries would cure many of the the ills of humankind. Penicillin and other antibiotics, first discovered and marketed in the 1940's, were new weapons against that most ancient of plagues -- the epidemics of infectious disease which periodically wiped out whole populations. These discoveries seemingly ushered in a disease-free era. Over the past ten to fifteen years they have revealed the sting in their tail. As the late twentieth century discovered, the antibiotic weapon has turned on the humans who wielded it. An increasing number of bacteria have mutated into antibiotic resistant superinfections, which can be cured, if at all, with fluids, rest, and time. Because of these infections, many debilitated hospital patients are kept in isolation. The end of the twentieth century witnessed a resurgence of potentially fatal forms of nineteenth century diseases: meningitis, group *a* hemolytic *b* streptococcal disease which causes scarlet fever, puerperal fever (which caused so many deaths in childbirth in the nineteenth century) and necrotizing fasciitis (flesh-eating disease). In other areas of medicine, cures are elusive. In spite of many new combinations of chemotherapeutic agents and new discoveries in cancer treatment, cancer has not been eradicated. AIDS remains without a cure.

Others are attracted to the almost mystical claims of some forms of alternative medicine. For example, some claim that medicine is entering a third era. Proponents of this point of view claim that humankind is entering a period in which consciousness will expand and individuals will become more attuned to the invisible healing energies of the universe. Larry Dossey, MD is a proponent of this view (see Dossey, 1999). Dr. Peter de Crippens, a Paris-based homeopath, claimed that people at the end of the twentieth century were going through a "massive transformation and expansion of human consciousness...[and that] medicine is fast approaching the 'third' and final step [after the first stage, the physical dimension of healing and the second, the psychotherapeutic] which consists in 'rediscovering' and including also the *spiritual dimension*" (Crippens, text of McGill

lecture, November 24, 1997). This sanguine belief is found in much New Age literature.

Ours is a society that no longer trusts the twin authorities of religion and medicine. But its individuals still seek comfort and cure when assailed by spiritual, psychological or physical ills. Many forms of alternative medicine offer both comfort and cure. In the words of sociologist of religion Robert Fuller, alternative medicine is a form of “unchurched religion” (Fuller, 1989) which, for many, satisfies the need both for meaning and for transcendence. Healing rituals satisfy metaphysical needs.

The dominant biomedical system, to some extent, occupies the role the Catholic Church did in the Middle Ages. One could see all alternative forms of medicine in North American society as intriguing heterodoxies. The high priests of medicine, in the form of the various councils and colleges of physicians, determine which types of medical belief will be admitted to the canon, which types will be classified as apocrypha and which will be banished as dangerously heretical. Inquisitors, who may take the form of agents from the Health Protection Branch of the (Canadian) Federal government or from the different colleges of physicians, become the new inquisitors. Disciplinary committees or the regular courts are used for the heresy trials.⁸ Paul Martel, a Québec lawyer specializing in the legal aspects of alternative medicine, makes this point:

It has its saints, the authors of great scientific discoveries. It has its churches and its chapels, the hospitals and the clinics; its celebrants, the doctors. Its black habit has been transformed into a white lab coat and the crucifix is a stethoscope. Its seminaries are faculties of medicine. It has its liturgical language, the scientific vocabulary which, by chance, is...Latin! It also has its conclaves, scientific congresses; it is patriarchal, relegating feminine values to a second level; it is infallible in what it knows and preaches; it promises the faithful (“Outside medicine, there is no salvation!”) salvation,

⁸Church officials of the Middle Ages forbade the use of amulets to heal but promoted holy relics (Kiekhefer, June 1994, 832). The canon is drawn up by those in power, in medicine as in the church, but it is sometimes difficult to see much difference between some aspects of the official and the unofficial practice.

health and, eventually, who knows, eternal life. It is sectarian and its Inquisition attacks infidels and witches (pursued for the illegal exercise of medicine) who are heretics (disciplinary sanctions; Code of ethics).

It has confession: the sinners (the sick) come to find absolution (medical treatment) but, unlike the Church, it is unable to say "Go, sin no more" (prevention).

It has a pope, apparently named for life [this seems to be an allusion to the then head of the Corporation des médecins de Québec].

However, contrary to the Church, the Bible (the canons of medical science) is not set in stone and is subject to continual revision. It is nothing less than the word of God ⁹(Martel, 1992, 222, trans. O'Rourke).

Incompatible discourse as a specific difficulty

Some believe that difficulties may arise from the fact that alternative medicine and biomedicine occupy two universes of discourse (see Frohock, 1992). It is important to ask if we can hold alternative practitioners to ethical standards framed in the same concepts and language used in biomedical ethics. Orthodox medicine and alternative medicine use different explanations of the cause of illness, for example. A conventional physician would

⁹Tout comme l'Église, la médecine officielle a son dogme: les canons de la science médicale. Elle a ses saints, les auteurs des grandes découvertes scientifiques. Elle a ses églises et ses chapelles, les hôpitaux et les cliniques, ses célébrants, les médecins, dont la soutane noire s'est transformée en un sarrau blanc et le crucifix en stéthoscope, ses séminaires, les facultés de médecine. Elle a son langage liturgique, le vocabulaire scientifique, qui, comme par hasard, est...latin! Elle a également ses conclaves, les congrès scientifiques; elle est patriarcale, reléguant les valeurs féminines au second plan; elle est infaillible, du moins quant à ce qu'elle sait et prône; elle promet à ses seuls fidèles ("Hors la médecine, point de salut!") le salut, sa santé, et éventuellement, qui sait, la vie éternelle. Elle est sectaire et a sa propre Inquisition, qui s'attaque autant aux infidèles et aux sorcières (poursuites pour exercice illégal de la médecine) qu'aux hérétiques qui sont dans ses propres rangs (sanctions disciplinaires, Code de déontologie).

Elle donne la confession: les pécheurs (les malades) viennent chercher chez elle l'absolution (les traitements médicaux) mais, à la différence de l'Église, elle ne les accable pas avec un: "Va, ne pêche plus!" (Prévention).

Elle a même un pape, apparemment lui aussi nommé à vie.

Cependant, contrairement à L'Église, sa Bible (les canons de la science médicale) n'est pas coulée dans le ciment et elle fait l'objet de révisions continues. Ce n'en est pas moins la parole de Dieu... Martel, 1992, 222)

normally reject the concept of “energy” and its excess or weakness as a diagnostic category whereas many forms of alternative medicine are grounded in the theory of vital energy. CAM practitioners may treat using intuitive rather than empirical data. How can moral discourse “find a common ground” when fundamental assumptions conflict (Frohock, 1992, 237)?

This is a serious difficulty in ensuring such standards as informed consent in the metaphysically or spiritually based forms of alternative medicine. Political scientist Fred Frohock points out that it is difficult to reconcile the ethical principles of biomedicine with those of holistic medicine since the values and language of each differ (Frohock, 1992, 237). However, it is important to note that not all forms of complementary and alternative medicine are of this type.

Frohock’s book is a study of “liberal dilemmas that occur when incompatible ontologies enter public space” (Frohock, 1992, viii) and is particularly helpful to those engaged in comparative ethics. Frohock suggests no matter how consent is conceived or phrased, one cannot reconcile the differences between the two approaches to health care because of the different languages used. (Frohock, 1992, 238). There is a way out, however. In examining the relationship between the authority of the state and an individual’s belief in particular healing methods it is suggested that

[when] unconventional outlooks may jeopardize the public interest in maintaining health and life...the state....should act as an umpire, ensuring that tolerance and neutrality are maintained among competing accounts of health, disease, and healing, and that individual rights are protected against external interference (review of *Healing Powers in Unconventional Therapies* for *Professional Acceptance*, May/June, 1993, 8 and see Frohock, 1992, 239, 272-273).

In conflicts between holistic and allopathic medical values, the state meets the terms of the liberal ideal with regulations that do not depend on the particular worldviews of either community but rather on a set of procedures that are reasonably empty of substance (Frohock, 1992, 32).

The liberal state must keep itself separate from the partisan views of those in either the conventional or the alternative camp and “find some high ground independent of these communities of belief...”(Frohock, 1992, 32). This is a method, propounded by H. Tristram Engelhardt Jr., which emphasizes procedure over substance.

The issue of incompatible discourse touches on many of the issues to be discussed in this thesis. For example, conventional medical experts might wish, in the interests of public health, to control or ban therapies based on what they see as weak or unproven scientific principles. By whose standards ought these therapies to be judged and what are the limits of biomedical paternalism?

If conventional and alternative medicine represent opposing belief systems, it may be difficult to apply to CAMs models used to regulate conventional medicine, as was noted by Patel (Patel, 1998, 73) and Stone and Matthews (1996, 5). The thesis will examine the methodological problems which might arise from the application of the principles of conventional bioethics to alternative medicine. Many types of alternative medicine are based on ideas that could be described as religious or spiritual. As Margaret Battin points out in *Ethics in the Sanctuary*, “professional ethics is completely unequipped to deal with ...central religious concepts” (Battin, 1992, 15). Professional ethics, with its emphasis on autonomy, non-maleficence, beneficence and justice “cannot tell us whether principles of religious morality, such as obedience to God or loyalty to a church, ever override these” (Battin, 15). One may have to look to normative religious ethics¹⁰ to find a principle satisfying to those whose belief in the spiritual aspects of healing leads them to ignore the demands of conventional bioethical principles. The methodological problem, Battin points

¹⁰Normative religious ethics establishes what is acceptable and justifiable.

out, is that those who accept a spiritual claim as true will “also accept as true precisely those religious claims that appear to settle (or disguise) the very kinds of moral problems [within religious institutions] that are to be examined...” (Battin, 16). The skeptical approach rejects and dismisses all spiritual claims (Battin, 16).

If incompatible discourse is seen as a problem, the difficulty may lie in the way in which the discourse is framed. To borrow from the field of ecclesiology, we might see the current desire to build bridges between the alternative and conventional community as an activity similar to that which took place in the early days of religious ecumenism. After several centuries of polemic, the Christian churches in the 1950's began to seek common ground. The ecumenical movement blossomed to incorporate avenues of dialogue with non-Christian religions even though each group held fundamentally different beliefs about the nature of revealed truth. In the Vatican II document *Nostra Aetate* (28 October 1965 in Flannery, Ed., 1975), the Roman Catholic Church spoke approvingly of the treasures to be found in religions seemingly so different from Christianity. Dialogue is possible if respect exists, even when core beliefs differ radically.

This thesis will not criticize belief in the claims of alternative medicine but try to respectfully present this type of medicine's core values. Nor will it argue whether or not different types of alternative medicine are effective. Its sole aim, particularly in section four, is to see whether or not bioethical, theory, principles and methodology can be applied to alternative medicine and to expose areas which create particular methodological difficulties. The analysis should reveal ethical dilemmas inherent in some aspects of the practice of alternative medicine, state the ethical principles involved and examine critically the values which emerge (see Shannon, Ed., 1981, 8-10). Because bioethics is interdisciplinary, and is

intended to guide those who practice many forms of health care in resolving dilemmas, the analysis should yield a set of guiding principles or norms.

Conclusion

Health care appears ready for a change. The Canadian health care system, like government-funded systems in other industrialized nations, seems at times to be in a state of crisis.

While publicly-funded health care becomes financially poorer, science and technology offer new and expensive diagnostic techniques and treatments: magnetic resonance imaging which can map every tissue and organ in the body making invasive diagnostic procedures a thing of the past, organ transplants, new and expensive drug treatments for cancer and AIDS and even the manipulation of DNA in the human embryo or the storage of ovarian tissue so that young women rendered infertile by medical treatment can conceive. Parallel to advances in science, chronic diseases such as asthma, allergies and diabetes, however, have increased in the population. Improvements in neonatal care and advances in the treatment of adult diseases mean that more people live long enough to contract a treatable disease.

Most people who suffer illness hope to find a cure. Reading about what is possible, many demand more of their health-care system. These challenges present society with an opportunity to re-think the entire biomedical enterprise. It is at this point that alternative medicine might make important contributions. A new generation of physicians is demonstrating interest in alternative medicine and, as we have seen, some medical societies are attempting to build bridges to the alternative world.

It is too soon to tell whether or not the Canadian medical societies and provincial organizations are ready to collaborate more closely with the practitioners of alternative medicine but when they do, ethicists are well-placed to build the bridge that will help the two

sides to communicate. Bioethicists may be able to work with governments and associations of alternative practitioners to determine how to protect the consumers of alternative medicine. They may also bring what they have learned in conventional clinical bioethics to alternative practitioners who ask for help in designing codes of ethics or clinical trials (see *Unconventional therapies vie for professional acceptance*, 1993, May/June, 6-7).

This chapter has introduced the topic by looking at the current state of complementary and alternative medicine as reflected in medical journals, medical associations, by governments, universities and hospitals. It has briefly examined the spiritual and religious content of complementary and alternative medicine and the difficulties this can create when conventional medicine attempts to communicate with those in the alternative field. The next chapter will present the bioethical model on which the thesis is based. It will look, in particular, at the four-principles theory that originated in the *Belmont Report* (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) and was elaborated by ethicists Tom L. Beauchamp and James F. Childress.¹¹ The four principles are autonomy, non-maleficence, beneficence and justice. Section four will take these classical principles and apply them to alternative medicine. An important question is the extent to which ethical guidelines developed for conventional medicine can be applied to alternative medicine. It may be that some types of alternative medicine require different, or additional, ethical guidelines. Because an understanding of definitions is crucial to all the studies measuring extent of use, chapter three will offer various definitions of alternative medicine, describe various types of alternative medicine and order them into taxonomies. Chapter four will discuss those who use alternative medicine and how and why they use it.

¹¹Principlism is used in this thesis as an organizing framework. The descriptive account is organized using the four-principles theory.

Section three, chapter five will be devoted to historical understandings of healing beliefs and religion that are important to an understanding of present practice. It will present some of the antecedents of alternative/complementary medicine and healing beliefs, tracing the continuities and discontinuities in these beliefs from the Anglo-Saxon era through Renaissance neoplatonism to the Enlightenment and the theosophical and metaphysical healing movements of the eighteenth and nineteenth centuries. Alternative medicine is not just a type of medicine; it incorporates a wide range of practices that have more in common with religion and spirituality than with conventional medical practice. Understanding this is important to the ethical analysis because it may require different ways of applying conventional bioethical theory and principles.

Chapter six will look at alternative medicine and religion. Consumers of complementary and alternative medicine should be informed about the religious or spiritual beliefs in which a practice is grounded. The chapter will examine the ethical problems that arise because of the religious and spiritual influences on complementary and alternative medicine.

Section Four will be devoted to the ethical issues raised by the use of alternative medicine, grounding each in one of the four principles. Chapter seven will look at autonomy and informed consent; chapter eight will examine proof through research that products and treatments are safe and efficacious and look at claims of efficacy and the verification and disclosure of risk (a practitioner committed to non-maleficence will want to ensure that products and treatments cannot harm; a practitioner committed to beneficence will want to ensure that they are safe and effective). Chapter nine will discuss alternative medicine and the right of the state to control healing practices. Chapter ten continues this discussion, examining accountability at the local level; control by professional groups; licencing, registration and certification; education and training and codes of ethics. These are all

aspects of non-maleficence and beneficence. Chapter eleven will discuss the principle of justice, the various types of justice and how this principle relates to such issues as complaint systems, sanctions against incompetent practitioners, public information, equitable access, and conflicts of interest.

The conclusion will address the ethical challenges raised by popular interest in complementary and alternative medicine and ask whether or not we can extend the biomedical ethical model to alternative medicine. An important question is whether or not the practices of complementary and alternative medicine raise other issues that are not answered by the application of the biomedical ethics model? Does, for example, the practice of alternative medicine raise new ethical challenges? Do these challenges require a new schema of ethical analysis or new principles?

Chapter Two

Complementary and Alternative Medicine and Biomedical Ethics - Applying the Standards and Practices of Bioethics to Complementary and Alternative Medicine

Introduction

A 1992 issue of *Guide Ressources*, a Québec publication devoted to alternative medicine, describes a woman who went to an acupuncturist complaining of sharp pains in her chest. "It's your kidneys," the acupuncturist said as he temporarily alleviated her pain. The client did have kidney problems, but she also had lymphatic cancer, diagnosed by blood tests some days later (Lamontagne, 1992, 33). This is not to suggest that alternative medical practitioners are incompetent. Many are competent and ethical within their own terms of reference and field of practice and conventional medical doctors also make diagnostic errors. Conventional medicine, however, has clear and consistent methods of training and systems of accountability; with some exceptions, like chiropractic and acupuncture, the vast and diverse field of alternative medicine does not. Since many Canadians consult alternative practitioners, it is important for the protection of the public that alternative practitioners be able to assure their clients that they are professionally trained, accountable to a recognized organization and adhere to a code of ethics.

Health care institutions across North America post codes of ethics and bills of rights in prominent locations so that patients are aware of their rights. Patients are assured that they have the right to informed consent, which means they must be told of the benefits and risks of treatment, the freedom to refuse treatment, the right to choose a practitioner or establishment rather than have one imposed and the right to know their practitioner's

credentials. Other rights include equitable access.

The very nature of the various alternative modalities may make some of these rights difficult to apply in the same way in which they are understood in the practice of conventional medicine. However, the ethical standards which regulate the practice of conventional medicine ought equally to apply to all forms of alternative therapy so that patients, when they choose and consent to alternative therapy, are sufficiently informed and sufficiently free to make a clear and informed decision. They should also be able to use alternative medicine with the confidence that these practices are government regulated and they should be able to choose a properly trained and licenced practitioner.

This thesis is based on the hypothesis that alternative medicine will assume growing importance in the health care of Western populations. If it is to do so, it may be timely to analyze some of the ethical issues raised by this trend. At the moment in Canada, the many types of alternative medicine are practiced with very few legislative controls, standards of training or proofs of efficacy. When members of the public become clients of alternative practitioners, it is not at all clear that the ethical standards fundamental to the practice of biomedicine are applied in a consistent manner or applied at all. Some of the concepts, for example, informed consent, are relatively new in conventional medicine. The idea that the patient must receive all reasonable information about proposed treatment became enshrined in U.S. law only in 1957 (*Salgo v. Leland* 1957 in Katz, 1984, 60-61) and in Canadian law in 1980 (*Reibl v. Hughes*).

Lawyers Julie Stone and Joan Matthews see the increased interest in legal and ethical issues in conventional medicine as paralleling the current interest in alternative medicine. While many believe that people turn to alternative medicine because they find conventional

medicine wanting, Stone and Matthews believe that what is lacking in conventional medicine is “medical *regulation*.” By this they mean that some think the profession of orthodox medicine functions under regulations designed more to protect doctors than defend patients. Grievance procedures, they say, are inadequate and “disciplinary procedures...widely perceived to be outmoded and ineffective...” They conclude by saying that “many of the perceived problems within orthodox medicine are about *regulatory malfunction* rather than the *practice of medicine*” (Stone and Matthews, 1996, 4). It is regulation, they say, that “provides the framework for, and to some extent determines the nature of the medical encounter.” Where regulation is weak, lacking or non-existent, “public confidence in doctors, and the system within which they work, will plunge” (Stone and Matthews, 4). Stone and Matthews are describing the English health care system, and some of their criticisms may not apply in Canada.¹²

Stone and Matthews see “largely unexplored” legal and ethical issues in the “inter-connectedness between the perceived failure of orthodox medicine and the apparent success of complementary medicine” (Stone and Matthews, 1996, 4). These parallel developments may bring about change in both fields. The way in which conventional medicine is regulated may appear to favour the powerful physician, but, at least, the field is regulated. Alternative medicine is, in most parts of Canada, totally unregulated -- a situation that is difficult to defend ethically. Stone and Matthews insist that alternative medicine must be regulated, just as conventional medicine is (Stone and Matthews, 1996, 3). But difficulties may arise if the

¹²Patients in any province in Canada may lodge a complaint about a physician to the provincial College of Physicians. Many investigatory procedures, both within hospitals (in Québec the Council of Physicians, Dentists and Pharmacists of an institution investigates complaints about doctors, dentists and pharmacists) and at the level of the provincial colleges, may conclude with an explanation that “no medical malpractice has been found”. Patients, needless to say, may find this to be a feeble response to an often anguished criticism of a physician.

regulatory models used in conventional medicine are applied as a standard to alternative practices. Stone and Matthews see:

significant difficulties in viewing the regulation of complementary medicine primarily from the perspective of orthodox medicine: we argue that holistic therapies require more than just minor adjustments to the set of regulatory priorities that govern orthodox practice. ...the very discourse of medical law and ethics has been shaped by the prevailing doctor/patient relationship in which the doctor is the expert and the patient the passive recipient of treatment. Such a model cannot be readily transposed to a relationship based on mutual responsibilities and commitment in which information, and thus power, is shared (Stone and Matthews, 1996, 5).

Later in the book they say that the use of alternative medicine raises issues that go beyond the narrow confines of classical bioethics. Stone and Matthews ask if alternative therapies “can or should work within institutionalized settings?” They claim that medical ethics has limited itself by the way in which it has “delineated [its]...subject matter.” It tends not to focus on broader social issues (Stone and Matthews, 1996, 235).

Conventional medicine is so powerful that it can unwittingly co-opt those who work in parallel systems. For example, hospital chaplains once provided spiritual help to patients privately. They now join physicians, nurses and social workers in case rounds, documenting their conversations with the patients. Likewise, bioethicists, anxious to be taken seriously by the medical profession, may not challenge some medical sacred cows. Alternative medicine is in danger of following the same path as hospitals eagerly add therapies like Reiki or meditation to its arsenal of treatments. The parallel professions then become subsumed to the demands of the medical monolith and the parallel practitioners may become incapable of seeing fundamental problems in the way care is delivered to the patient.

Vimal Patel suggests that conventional bioethics has been dominated by the need to “accommodate evolving science, technology, and the legal system, and the basic biomedical belief that human beings can be considered as machines made up of parts and organ

systems” (Patel, 1998, 73). Simply transferring to alternative medicine the systems used to regulate conventional medicine may be forcing this “patient-centred, holistic approach to health care” into a jacket that does not fit (Stone and Matthews, 1996,7). This, according to Stone and Matthews, “must result either in laws which do not work, or in regulation which strips holistic medicine of much that is of real value” (Stone and Matthews, 7). This is an issue fundamental to any discussion of ethical issues in alternative medicine.

Stone and Matthews favour what they describe as “ethics-led regulation” which emphasizes ethical standards and the prevention of mistakes. They see conventional medicine as regulating itself retrospectively -- after the mistake has been made. Of necessity, this type of control focuses on disciplining those who have failed to adhere to the standards of the profession. Stone and Matthews place ethical conduct first so as to enhance standards and protect consumers from harm (Stone and Matthews, 1996, 225). Their method, which relies on an educational rather than a disciplinary approach, appears to offer a fruitful means of negotiating the seemingly incompatible aims of conventional and alternative medicine. Ethics should be part of all complementary and alternative medical training.

To understand the ethical principles that could be used to guide the practice of alternative medicine, it is important to understand a little of the evolution of ethics within the field of conventional medicine. This chapter will look at bioethics, its history, theories and principles and describe the theory, principles and methodology to be used in the analysis of the practice of alternative medicine. The thesis itself will examine specific forms of alternative medicine from the perspective of conventional bioethics. The many types of alternative medicine will be presented in the next chapter. The thesis will exclude Chinese medicine and Ayurvedic medicine from the analysis as these are not alternative in their own cultures.

Various types of alternative medicine will be analyzed according to the four principles approach (principlism) developed in the Belmont Report (1978) and elaborated by Tom L. Beauchamp and James F. Childress (1994): autonomy, non-maleficence, beneficence and justice. These four principles are widely used, are based on the central Western democratic tradition and are embedded in our legal system. Beauchamp and Childress point out that they are part of the “common morality and medical tradition” and conclude that they “are central to biomedical ethics” (Beauchamp and Childress, 1994, 37). They are most useful when analyzing bioethical issues that lend themselves to legislation and are helpful to those analyzing ethical issues in alternative medicine. Stone and Matthews used them as the core of their “ethics-led” regulatory scheme (Stone and Matthews, 1996, chapter 13). These principles, developed in the United States, are known worldwide (Jonsen, 1998, 379). Because they are so widely used in biomedicine, they can serve as a common language and frame of reference to facilitate discussion between those in the alternative and the conventional medical field.¹³

¹³John H. Evans looks critically at principlism as a method of bioethical decision making. He notes that the four- principles approach was developed to facilitate ethical decisions about medical research but that, since the publication of the *Belmont Report* in 1978, the method has come to be used wherever groups “need to legitimate decisions to people whom decisionmakers do not know.” Principlism became important to governments because they need to show the public that they are acting transparently and because the government is bureaucratic. The American public, Evans says, demands that governments, or government-mandated bodies like a university hospital’s institutional review board, be able to show how they arrived at an ethical decision; they cannot simply rely on the discretion of individual members to make moral judgements. The ethical reasoning must be capable of being judged by the public. Principlism, because it provides a set of clearly understood standards, suits bureaucracies that must make decisions about whether grant money is to go to a research project (in the U.S., principlism is a system legally imposed on those who wish to receive federal research funds). Since 1978, principlism evolved to the point that it is applied to an increasingly wide variety of ethical issues, largely because the state is involved in so many of those issues. Principlism itself, according to Evans, has become dominant and “institutionalized” due to several factors: the growing acknowledgment that bioethics is a profession with a distinct body of knowledge; the teaching of principlism by “elite bioethicists” to “average members of the profession”; the consequent dominance of principlism through workshops and publications, particularly those of Beauchamp and Childress. According to Evans, the experts involved in “foundational bioethics” had promoted principlism, consequently, those new to the field

Several principles have been proposed as additions to the four principles on the belief that they do not adequately cover the issues raised. Although other principles -- such as truth-telling or contract-keeping -- could be added to this schema, the thesis will follow Beauchamp and Childress who subsume these principles under the general categories non-maleficence and beneficence.

This thesis will apply these principles to: (1) The doctrine of informed consent as it is practiced in alternative medicine (autonomy); (2) safety and efficacy of alternative medicine and ethical research methods appropriate to alternative medicine (non-maleficence and beneficence); (3) alternative medicine and the right of the state and medical societies to control alternative healing practices (non-maleficence and beneficence); (4) professional accountability which includes licencing, education and training, self-policing and codes of ethics (beneficence, non-maleficence)¹⁴; (5) disciplinary procedures, sanctions and complaint handling systems; equitable access; fair exchanges between practitioner and client (justice). It will also ask whether or not these principles can be applied to alternative healing with a strong religious or spiritual content.

History and Evolution of Bioethics

“know that to continue as a bioethicist they cannot invent their own ethical system (unless they are lucky enough to be elites working on ‘foundational’ bioethics). As they are asked to write on or decide issues far removed from the first bioethical issue, human experimentation, the tendency to use principlism will be quite understandable.” Evans points out that some “elite” bioethicists have argued that principlism is a type of reductionism that cannot fully “capture the moral life” (Evans, 2000, September-October, 31- 38). Nonetheless, principlism is a valuable method for anyone trying to develop standards for government legislation.

¹⁴ Public policy is enforceable; policies of hospitals and professional societies may affect public policy but are private.

Bioethics as a field dates back to the late 1960's and 1970's in the United States. The term ethicist, as used today, was not known until that time (Gustafson in Fox., 1996, November-December, 6). While some bioethicists date the birth of clinical biomedical ethics to a 1962 article by Shana Alexander, on the availability of hemodialysis, (Ahronheim, Marengo & Zuckerman, 1994, 4), the term bioethics first appeared in 1971 in Van Rensselaer Potter's *Bioethics: Bridge to the Future* (Roy, Williams, Dickens, 1994, 3). It then was used in a paper by Daniel Callahan in 1973 (Jonsen, 1998, 27). Ethicist Albert R. Jonsen describes the period 1947 to 1987 as the period in which the foundations were laid for this new discipline (although the American Medical Association's 1847 Code of Ethics could be said to be the real foundation) but dates the official use of the term bioethics to its 1974 entry in the Library of Congress catalogue as a subject head citing the 1973 article by Daniel Callahan (Jonsen, 7, 27). Interestingly, Callahan does not like or often use the term (Jonsen, footnote, 79, 33). Beauchamp and Childress say that even by the late seventies, when they produced the first edition of *Principles of Biomedical Ethics*, "there was no sustained theory of biomedical ethics and no systematic account of its principles and normative rules" (Beauchamp and Childress, 1994, 23).

David J. Roy, John R. Williams and Bernard M. Dickens, in *Bioethics in Canada*, point both to bioethics' newness and its antiquity. Modern bioethics inherits two thousand years of ethical reflection on medical practice. The Greek physician Hippocrates (5th century B.C.E.) is most well known for the Hippocratic oath which is seen to be at the heart of medical ethics in the West. Hippocrates was a foundational thinker for Muslims. From its beginning in the seventh century C.E., Islam concerned itself with medical practice and medical philosophy. Islamic medical schools and textbooks, including those on ethics, predated Christian activity in this area. Jews did not rely on Hippocrates but turned to the Bible and rabbinic scholars for guidance in medical judgements. Moses Maimonides (1135-1204

C.E.) was the most influential thinker. Christians combined the teachings of Hippocrates, the Muslim scholar Ibn Sina (980-1037 C.E.) and Maimonides. By the thirteenth century, Aristotle (384-322 B.C.E) became a particularly important influence (Roy, Williams, Dickens, 1994, 4-5; 8-9).

A comprehensive body of moral theology was produced in the twelfth and thirteenth centuries with Thomas Aquinas asking questions of ethical importance. He considered whether euthanasia could ever be acceptable. The answer was “no”. He also asked whether a physician is “morally obliged to treat the poor without charge” and answered that the physician was obliged if the patient would otherwise die (Roy, Williams, Dickens, 1994, 9). Some methods of ethical debate used today were developed between the fourteenth and eighteenth centuries. Casuistry, for example, has its roots in the case studies Catholic priests used to make judgements about the sinfulness of particular actions. Casuistry has been extremely influential in the development of Catholic medical ethics and this method has been revived by Stephen Toulmin and Albert R. Jonsen (Roy, Williams, Dickens, 1994, 9).

After the Reformations, physicians took control of medical ethics, moving away from the dictates of the Church. The Enlightenment (1650-1800) was a philosophical movement which rejected religious control of medical issues, substituting objective, rational and “professional” standards. In this era, philosophers moved from focusing on practical ethics (*phronesis*) to what they believed to be the more intellectually respectable field of ethical theory (Roy, Williams, Dickens, 1994, 5-7; 9-10).

Philosophical theory has been enormously influential in the field of bioethics. Philosophers focused on establishing rules and terms of discourse, balancing one ethical system against another. This theoretical focus tended to eclipse the day-to-day issues of actual medical

practice. According to Roy, Williams and Dickens, only by the late 1960's did philosophers reclaim the Aristotelian emphasis on practical knowledge or *phronesis* (Roy, Williams, Dickens, 1994, 8). In contrast, religious thinkers were always concerned with practical issues. Roman Catholic scholars in particular issued many documents, articles and books on medical ethics, particularly in the 1940's and 1950's (Roy, Williams, Dickens, 10).

By the nineteenth century, Thomas Percival (1740-1840) emerged as a foundational writer in the field of medical ethics. His work, *Medical Ethics* (1803), formed the base of the codes of medical ethics adopted by the American Medical Association in 1847 and the Canadian Medical Association in 1867. In the early 1950's, nursing associations created their own codes of ethics. Nonetheless, physicians dominated the field of medical ethics until the 1960's (Roy, Williams, Dickens, 1994, 6).

Traditional medical ethics was centred on physicians who alone decided what was medical “truth”. Codes of medical ethics written in the nineteenth century were devised by doctors who exhorted their colleagues not to consort with what they called “quacks”. In some cases, they are still forbidden by their codes of ethics to do so. For example, article 2.03.35 of the Code of Ethics of the Québec College of Physicians says that “the physician must not, in the exercise of his profession, consult with a charlatan, bonesetter or empiric (quack), neither to furnish information nor to collaborate in any fashion with these people”¹⁵ (trans. O’Rourke, Code de déontologie des médecins, Collège des médecins du Québec, 1995).

This was true up through the twentieth century. The history of medical ethics is the history

¹⁵2.03.35 “Le médecin, dans l’exercice de sa profession, de doit pas avoir de consultation avec un charlatan, un rebouteur ou un empirique, ni leur fournir de renseignement ni collaborer de quelque façon que ce soit avec eux.”

of power relationships between doctor and patient. The physician held the power and knowledge, and did not usually share it (Brody, Rygwelski and Feters, 1999, 46-48). Conventional medicine has also been extremely powerful in determining the type of health care society offers its citizens. Hence medicare does not usually insure alternatives.

By 1960, society had changed radically. On the one hand, advances in science and technology promised new cures and new hope. On the other, an increased focus on human rights, a loss of respect for authority, and moral pluralism all contributed to a radically different approach to medical decision-making. In earlier times, doctors knew their patients personally. The growth of large and highly specialized hospitals meant that doctor and patient often met as strangers. The language of rights became the currency of communication and the public demanded stricter regulation of medical doctors. Non-physicians, including other health care professionals, demanded to be consulted when medical decisions were to be made (Roy, Williams, Dickens, 1994, 11-12).

In the early stages of the bioethics movement the typical bioethicists were moral theologians and moral philosophers, invited by physicians and hospitals to contribute their expertise to difficult cases, or else they were physicians known to be effective at dealing with difficult ethical cases (Baylis, 1994, 1). In this period, various bioethics research centres were developed -- The Institute of Society, Ethics and the Life Sciences (known as the Hastings Center) in 1969; the Kennedy Institute of Ethics at Georgetown University in Washington, DC in 1971 (see Jonsen, 1998, 20) and, a first for Canada, the Clinical Research Institute of Montreal's Centre for Bioethics, in 1976 (Roy, Williams, Dickens, 1994, 13). The McGill Centre for Medicine Ethics and Law was founded in the early 1980's and an offshoot -- the Biomedical Ethics Unit of McGill University -- was founded in 1996.

Bioethics is an interdisciplinary field and its practitioners and theorists include lawyers, social scientists, medical doctors, nurses and other health care professionals as well as moral philosophers, theologians and members of the clergy. Law has influenced the regulatory aspect of professional practice although ethical debate does not end with an appeal to the law. Over the past thirty years, bioethicists have contributed to state and provincial legislation, developed codes of ethics and practice, worked directly with physicians and patients to help in decision-making about difficult or controversial issues. While health care professionals have always paid attention to moral issues in the practice of their profession, the evolution of bioethics has brought moral debates into the public arena. A vast corpus of literature has been produced, providing many tools with which to engage in moral discourse. There is little excuse for "moral muteness" (see Bird and Waters, 1989), a condition in which a person faced with a moral dilemma lacks the concepts and language with which to articulate and analyze it. While many of the moral arguments of our society are severed from their roots in classical philosophy or moral theology (see MacIntyre, 1984, 2, 10-11) many people feel a need to ground their moral decisions in some concrete body of authoritative knowledge. With the general decline of religious authority, people turn to legislation or codes of conduct to guide their thinking on specific issues. It seems timely, therefore, to develop guidelines for the ethical analysis of alternative medicine.

Howard Brody, MD and the two co-authors of his paper *Ethics at the Interface of Conventional and Complementary Medicine* (physicians Janis M. Rygwelski and Michael D. Fetter) believe that the state of teaching and research into the ethics of complementary and alternative medicine is roughly where conventional bioethics was in the 1970's. In those days, they say, when the field was growing, medical ethics textbooks were largely made up of case descriptions with commentaries. This method of applied ethics made the nature of the various dilemmas very clear. Brody and his co-authors believe that the case-study

method would be useful in the teaching of the ethics of complementary and alternative medicine as the cases would focus on difficulties faced by those who actually practice in the field. It would also help in research and education (Brody, Rygwelski and Feters, 1999, 55). This is a return to Aristotelian *phronesis*.

Until recently, little consideration has been given, and even less written, about the ethics of alternative medicine. Julie Stone and Joan Matthews, in their 1996 book on legal aspects of alternative medicine, insist that regulation will not work unless it is grounded in ethics (Stone and Matthews, 1996, 225). James M. Humber and Robert F. Almeder edited *Alternative Medicine and Ethics* in 1998 but their book is uneven and not comprehensive. The work opens with an essay that contemptuously dismisses “alternative” medicine (author Stephen Barrett, MD’s quotation marks) as fraudulent. Stephen Barrett is a well-known spokesperson for the National Council Against Health Fraud and his work tends more towards polemic than a nuanced critique of alternative medicine. This provocative article is followed by an essay from a scientist who argues that conventional medicine should be more open to alternative types of healthcare. Of the final four essays, two discuss the issues raised by incorporating alternative medicine into healthcare plans and insurance schemes, a third discusses legal and ethical problems when prayer is used to heal children. The last essay examines ethical challenges in pharmacy. K.V. Iverson, in a review of the book, says that it addresses only a few of the ethical issues posed by alternative medicine but he believes that it will help readers to formulate their own ethical questions (Iverson, 1998, November 11, 1633). Missing from the book is an in-depth treatment of the following issues: the crucial role of informed consent; the ethical problems surrounding research into alternative medicine; ethical issues surrounding public and private legislation and regulation, training and accountability; the ethical questions posed by the spiritual content of many alternative practices used by adults.

Much of the bioethical literature on alternative medicine appears in journals where many authors focus on safety. An article on the ethics of alternative medicine in the November 11, 1998 issue of the *Journal of the American Medical Association* insists that alternative medicine, if recommended to patients, must be free of risks. Only in passing do the authors examine the deeper issues of free choice and informed consent (Sugarman and Burk, 1998, November 11, 1623-1625). Some practitioners and clients, viewing alternative medicine as a purer and more natural form of medicine (Kaptchuk, 1996, April 6, 972), may believe that its practice is inherently moral. The philosopher Margaret Battin makes the same point when she applies the methodology of professional ethics to organized religion, using it to identify the moral issues within organized religion itself. She points to the fact that organized religion has escaped ethical scrutiny partly because of the belief that ethics is “derived from religion and hence cannot be used to critique religion itself” (Battin, 1990, 2-3). The section on alternative medicine and religion will discuss some practices of alternative medicine that appear to have more in common with religion than with conventional health care. They may thus remain unexamined from the perspective of biomedical ethics. This thesis is also an exercise similar to Battin’s in that it applies theories, principles and methodologies from one field, in this case biomedical ethics, to another, complementary and alternative medicine rather than biomedicine.

In a sense, conventional medicine and alternative medicine are two cultures, two religions, two paradigms. Some have compared the powerful position of conventional medicine to that of the Roman Catholic Church prior to Vatican II (see Martel, 1992, quoted in the last chapter). Conventional medicine believes that it preaches “the true gospel” and offers the only true “sacraments”. But medicine is becoming more “ecumenical” these days. This thesis is an attempt to develop tools of discourse that will enable the two groups --

conventional and alternative medical practitioners and ethicists -- to communicate without engaging in polemic. The tools of discourse are theory, principles and methodology.

Theory

According to Jonsen, all disciplines have a central theory, as well as “alternative theories” which enable the academic to locate, combine and assess data. Jonsen adds that moral philosophers have been quite relaxed in their attention to theory (Jonsen, 1998, 327).

What is ethical theory? Callahan, according to Jonsen, “suggested that the traditional methods of philosophy would continue to be central to bioethics” -- that bioethicists would have a thorough command of normative ethics (which establishes justifiable and acceptable moral views) and metaethical theories (used to analyze moral concepts). Danner Clouser, according to Jonsen, sees bioethics as ethical theory applied to medicine (Jonsen, 1998, 327). Beauchamp and Childress, in the first edition of their *Principles of Biomedical Ethics*, said that moral theories “seek to formulate and defend a system of moral principles and rules that determine which actions are right and which wrong” (Beauchamp and Childress, 1979, cited in Jonsen, 1998, 329).

Tom L. Beauchamp and James F. Childress, like Callahan and Clouser, see bioethics as applying the “familiar theoretical forms of normative ethics” to new problems (in Jonsen, 1998, 329). They describe the relationship between moral theory and moral practice as a dialectical process. Theories make sense of experience but experience can be used to change theories (Beauchamp and Childress, 1994, 23). The goal of moral theories, they say, which is “central to its [the theory’s] account of justification” is to move from the general to the particular -- from theory to specific rules that approximate the decisions taken in everyday life. “The principles and rules in a theory” they describe as “a tributary with many forks

into different territories....” While conflicts cannot always be reduced or eliminated by creating principles or rules, specification of a principle (a way of making the abstract concrete) helps to move bioethics away from empty abstractions (Beauchamp and Childress, 1994, 31-32, 28-29). For example, autonomy is the principle that values the free choice of individuals. It is made specific by considering the specific situation (specification) and weighing it against other principles such as beneficence. This second step Beauchamp and Childress call balancing.

Because of bioethics’ pragmatism, a variety of theories have been used as the basis of bioethical analysis. This interdisciplinary approach also owes much to the early days of bioethics.¹⁶ As noted earlier, up to the 1960's, many pioneers in medical ethics were moral theologians and moral philosophers. This group tended to use classical deontological or consequentialist theories. The moral theologians were almost exclusively Roman Catholic. From 1965 to 1975, the theologians, now including a number of Protestants, continued to influence the field. This was the era in which Episcopalian theologian Paul Ramsey published *The Patient as Person*. Two other important bioethicists from this era with a theological background were the Methodist James Gustafson and the Jesuit priest Richard T. McCormack. During this period theologians attempted to develop approaches that would respect individual moral norms while adapting themselves to prevailing secular thought. As Albert Jonsen says, many bioethicists, as they entered the secular universities and hospitals, realized that many bioethical issues did not touch on the substance of faith (Jonsen, 1998,

¹⁶Bioethics is pragmatic in that it deals with concrete dilemmas. Because the foundational scholars in this field represented different disciplines, a variety of theories have served as the basis for decision-making in specific situations.

57-58).¹⁷ They developed methods and theories which could usefully be applied to a wide range of circumstances.

Out of these struggles emerged bioethical theories that attempted to create an ethic which would be acceptable to all in a pluralist society.

In the 1980's Robert Veatch attempted to ground medical ethics in its historic sources: Hippocratic theory; Judeo-Christian thought; liberal political theory. But each contradicted the other. Veatch then turned to what Jonsen calls the "more consistent, more universal" ethic of contract theory as expressed by Hobbes, Hume, Locke and Rawls. His "triple-contract" theory of medical ethics proposes a social contract in which people agree that the welfare of individuals is equally important and agree to principles by which all must abide. Professions such as medicine live within this contract and also establish "their mutual response" that determines relationships between professionals and lay people. Veatch added to the standard four principles three more: contract-keeping, honesty and avoiding killing. He believed that non-consequentialist principles such as autonomy had priority over consequentialist principles such as non-maleficence and beneficence (Jonsen, 1998, 329-330).

In 1986, H. Tristram Engelhardt developed the idea that ethics should focus on the process of conflict resolution, seeking out agreement to procedures to resolve disputes. His is a

¹⁷Recent writers have seen in the attempt to establish bioethics as a secular discipline a regrettable desire on the part of bioethicists to distinguish themselves from chaplains which has led to silence in bioethics about fundamental spiritual issues. Patients at the end of their lives are concerned with their dying; bioethics, Hardwig charges, focuses almost exclusively on the technology of resuscitation (should the respirator be turned off? When should artificial feeding be withdrawn?) to the neglect of issues perhaps more compelling to the patient (Hardwig, 2000, March-April, 28-30).

method of conflict resolution suited to a secular world in which earlier standards of moral authority are frayed and irreparable (see Engelhardt, cited in Jonsen, 1998, 330; Darvell, 1993, 15). Engelhardt believed that one could establish norms of acceptable conduct by relying on a procedural process rather than on issues of substance. He believed that ethics' role is to analyze and clarify, not determine moral content or prescribe norms. In the secular state, according to this view, procedures must be developed to protect free choice. Issues like abortion or euthanasia are considered to be part of private morality. In this community of strangers, rules exist to protect against abuses of power (Engelhardt cited in Darvall, 1993, 15). Engelhardt proposed that beneficence and autonomy are empty principles unless they are embedded in a secular ethic in which people living in different communities can come to agreement over minimal requirements for a shared morality. (Jonsen, 1998, 330).

Both Veatch and Engelhardt, according to Jonsen, resolved the problem of the conflict of principles by making deontological principles like autonomy more important than consequentialist ones like beneficence. This reversed the Hippocratic tradition of beneficence (Jonsen, 1999, 330-331) and was in tune with the emphasis on patients' rights that had become a standard aspect of medical care by the mid-eighties.

Edmund Pellegrino and David Thomasma attempted to restore the Hippocratic tradition without sacrificing autonomy. They elaborated a theory based on beneficence that stands in the Aristotelian tradition which focuses on moral virtue. They focus on patient vulnerability and look at the obligation of physicians (1) not to harm and (2) to treat each patient as an individual human being. They re-interpret beneficence as beneficence-in-trust. This is not paternalism but the physicians' duty to engage in dialogue with patients and to incorporate the patients' values into treatment, Jonsen says. Their theory places the principle of autonomy within the broader category of beneficence (Jonsen, 1998, 331).

Veatch, Engelhardt, Pellegrino and Thomasma were among the pioneers who developed bioethical theory yet “no single theoretical base for bioethics has been enthusiastically endorsed by the bioethics community” (Jonsen, 1998, 331). The reason, Jonsen suggests, is that bioethics took a pragmatic turn at a very early stage. Bioethics had to go to the bedside and solve problems from which theory may have seemed remote. Even if one theory proved to be helpful, it seemed one could commit to one theory on one occasion and another in a different set of circumstances. By the mid-1980's, interest in theory waned to come back to life in the 1990's (Jonsen, 331-332) with the coming of new or revived theories: utilitarian-consequentialism; Kantian obligation; character and virtue ethics; liberal individualism and rights; communitarian ethics; care and relationship ethics; casuist or case-based ethics; feminist ethics. While this thesis will examine complementary and alternative medicine from a principlist point of view, some consider these other theories to be superior to the four-principles approach.

Tom L. Beauchamp and James Childress are important scholars in bioethics. As noted before, their development of principlism has guided ethics courses world-wide. Beauchamp and Childress argue that any adequate ethical theory must feature the eight following criteria:

the theory must be:

- 1. Clear**
- 2. Internally coherent with no inconsistencies (for example, “strong medical paternalism is justified only by the consent of the patient”)**
- 3. Complete and comprehensive (the totally comprehensive theory would include all moral values. A weak one would include few).**
- 4. Simple, including no more norms than necessary.**

the theory must have:

- 5. Explanatory power, offering enough insight to help people to understand “the moral life”.**
- 6. Justificatory power. The theory should give *grounds* for belief in the theory.**
- 7. Output power. A good theory should help ethicists make judgements on issues that may have been non-existent or unimportant when the theory was devised. For example, a good theory should help people make judgements about the ethics of cloning humans, even if this is not yet possible. A good theory should help people to make new judgements.**
- 8. Practicability. It should be possible to make judgements that satisfy the theory. It does not propose utopian ideas. (Beauchamp and Childress, 1994, 45-47).**

Another way of looking at ethical theory is that, in ethical discourse, one can distinguish between standards for action and reasons for action. Without good reasons, standards lose ethical clarity. Reasons can take diverse forms which vary in how morally compelling they are. Standards can also take diverse forms. They may be grouped into three categories: (1) What is the right thing to do. (2) What are the objectives, ends and aims of the action. (3) What kind of person should one be.

In considering the right thing to do as a standard of conduct, the actor focuses on forms of behaviour that may be based on rules, principles or norms. The focus is on what is the right or wrong thing to do. An example would be “don’t tell lies”, based on the principle of veracity or “grant people freedom of speech”, based on the principle of autonomy.

In looking at ends as a standard, one focuses on the purpose of the act. For example, an

alternative practitioner may have as her goal the desire to make a person healthy. A surgeon may wish to save an injured limb. The outcome or good being sought is sometimes valued above principles. Some might justify lying to save a life, for example.

Standards based on the kind of person one should be is part of virtue-based ethics. The action is motivated by what is right, good or worthy and may not have a great effect. For example, the gospel story of the widow's mite demonstrates the value of intention over outcome. Strength of character goes a long way in addressing ethical problems in the practice of medicine. A virtue-based ethic, however, when used in medicine, can be misleading. One can believe with all one's heart that one has virtuous intentions and still do the wrong thing. Pure motives do not necessarily lead to virtuous outcomes.

Bioethical principles

Principles are grounded in theory and applied by methodology. Stone and Matthews distinguish between ethical principles and theories by saying that "ethicists attempt to justify ethical principles by reference to one or more ethical theories"(Stone and Matthews, 1996, 233). For example, a good healer considers his client's needs. This is based on the principle of respect for autonomy and is grounded in and justified by the Kantian theory that people have "intrinsic" not utilitarian value (Stone and Matthews, 233-234). The literature of ethics in Western culture is a literature of principles. The word takes on different meanings at different points in history. For Aquinas and Kant, the word referred "to the broadest foundations for moral reasoning" (Jonsen, 1998, 332). In the seventeenth and eighteenth centuries, principles referred to such "'sources' of morality in human nature [as]... 'sentiment,' 'reason,' 'sympathy,' 'conscience'" (Jonsen, 332). More recently, moral philosophers have seen principles as "action-guides" (Jonsen, 332). Beauchamp and

Childress do not greatly distinguish between rules and principles. They describe rules as “more specific in content and more restricted in scope than principles” (Beauchamp and Childress, 1994, 38). Principles are general; rules derived from principles can tell us what to do. Both rules and principles are distinguished “from the coherent, systematic body of norms that comprise *theories*” (Beauchamp and Childress, 38). Beauchamp and Childress argue that principles are grounded in “the common morality” by which they mean beliefs about right and wrong behaviour that are almost universally shared (Beauchamp and Childress, 105, 5). Not killing would be an example of common morality.

The legislation which mandated the U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research asked the commissioners to “identify the basic ethical principles” which should inform “the conduct of biomedical and behavioral researchers” working with humans (Jonsen, 1998, 333). The commission, with the help of many now well-known ethicists, produced *The Belmont Report* to guide medical research on humans in the United States. This focus on principles set the agenda for bioethics. The Canadian *Tri-Council Guidelines for Human Research*, issued in 1998, are similarly principle-based.

Almost from the beginning, therefore, “bioethics was an ethics of principles, formulated as ‘action-guides’” This was appropriate, Jonsen says, for a bioethics designed to solve problems and not just to think about them. However, it had the unfortunate effect of leading some to believe that bioethics could be reduced to a set of rules (Jonsen, 1998, 333). Like the law, however, what may appear to be simple principles are subject to many rich interpretations.

Though the principle-based approach, as elucidated by Beauchamp and Childress, has been

dominant in the teaching of bioethics, in recent years, the principle-based approach has been criticized by proponents of other approaches. Some say the four-principles approach is no help when the four principles invoked are in conflict (Stone and Matthews, 1996, 235). For example, respect for the autonomy of a patient refusing life-saving treatment is difficult to reconcile with the principle of beneficence. Other criticisms include the danger of focusing on principles to the detriment of considering other ethical issues (see Stone and Matthews, 235). A physician may, for example, so over-value autonomy that she makes no comment when the patient proposes to avoid treatment for stage 2 breast cancer and drink a herbal remedy instead. At the very least, the physician has an obligation, under the principle of beneficence, to provide her patient with sufficient information to make a choice and even to offer her own educated opinion. Or the physician might act on principle, focus too much “on...[her] duties and responsibilities...” without looking at the context of the problem (Stone and Matthews, 235). For example, patient autonomy may be impaired if the physician or practitioner recommending a treatment is receiving a research grant to study this illness or has invested in an alternative product. The researcher/physician may believe that her study or product will be of inestimable importance to human life in general and therefore pay less attention to her individual duty to the patient in the name of duty to all patients.

Beauchamp and Childress argued that all biomedical issues could be dealt with within the broad categories of the four principles. While some, like Robert Veatch, have added contract keeping, honesty and avoiding killing, Beauchamp and Childress argue that these categories are unnecessary as they are subcategories of the main principles (Beauchamp and Childress, 1994). Others have reduced the four principles to three, merging beneficence and non-maleficence. As a theory, the four-principles theory conforms to Beauchamp and Childress’ eight points (for example, it is clear, it covers many broad areas of medicine, can be applied

to future discoveries, teaches about the moral life and is easy to remember). However, Beauchamp and Childress claim that, while the four-principles approach is not complete for a system of normative ethics, it is “a sufficiently comprehensive framework for biomedical ethics” and does not need extra principles like truth-telling (Beauchamp and Childress, 1994, 46). The question this thesis will attempt to answer is whether Beauchamp and Childress’ principle-based theory works well for the field of complementary and alternative medicine. It will leave aside consideration of the utility of principlism when it is applied to conventional medicine. Accountability is a major issue in the field of complementary and alternative medicine in a way it is not in conventional practice. All physicians are licenced and accountable. If they perform badly, their hospitals, medical associations and patients all know where to go to correct the problem. Does accountability fall under the rubric of non-maleficence and beneficence, or does it require a different ethical principle? This is worth bearing in mind when looking at all the mechanisms available to enhance the accountability of complementary and alternative medicine. An even more complex issue is the role of religion and spirituality in complementary and alternative medicine. Might other principles usefully be applied?

We will now turn to the four principles.

The Four Principles

Autonomy

Autonomy is an overarching value in American society and dominates discussions in the field of bioethics. Jonsen traces the evolution of this concept, noting that, in the early centuries of the Common Era, the concept of autonomy played only a small role in discussions of free will; since the Renaissance, it came to mean “liberty from divine

dominance or social tyranny” (Jonsen, 1998, 334). Even at the beginning of the bioethics movement, autonomy was not a major concept. Modern moral philosophers were not interested in it and it cannot be found as an entry in the 1978 *Encyclopedia of Bioethics*. The concept came into its own as an answer to a problem raised by the debates over experimentation on humans. The question of whether the social good should overrule individual freedom was “a problem that needed a principle” (Jonsen, 1998, 334).

Respect for persons, according to Engelhardt, is the value on which people base their sense of moral responsibility. However, Engelhardt said in an essay for the National Commission for the Protection of Human Subjects of Biomedicine and Behavioral Research that produced the *Belmont Report* (1979) that it was the Kantian view, which emphasized autonomy, that prevailed (see Jonsen, 1998, 334-335). When Beauchamp and Childress wrote the first edition of *Principles of Biomedical Ethics* the notion of autonomy, defined as “a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself” (Beauchamp and Childress, 1st ed., 1979, cited in Jonsen, 1998, 335), was a central value. However, Kant emphasized that the individual exercised autonomy by acting in accordance with universally valid moral principles which satisfies the categorical imperative. Acting out of desire, impulse or fear is not to act autonomously (Beauchamp and Childress, 1994, 58).

Jonsen sees the modern understanding of autonomy as an amalgamation of ideas from three sources: the Christian message that emphasizes individual salvation transmuted into a secular valuing of the uniqueness of the human person; “a philosophical stress on the creativity of the individual” and the importance given to the individual in American life (Jonsen, 1998, 337). The idea is also a fusion of the Kantian “respect for persons” with John Stuart Mill’s belief that an individual’s liberty of action should not be infringed upon

unless his liberty deprives others of theirs (Jonsen, 335). The concept of autonomy is also derived from theories about the sovereignty of the state as propounded by Adam Smith as well as John Stuart Mill. The sovereignty of the individual is the foundation for the sovereignty of the state (Ahronheim, Moreno, Zuckerman, 1994, 12-13).

Bioethicists have tended to overvalue the autonomy model because it suits a pluralist society. When there is no consensus on matters of moral choice, it is simpler to emphasize procedures to ensure that those in authority do not override the choice of individuals. Much of the literature on bioethics came to emphasize autonomy and rights, influenced, no doubt, by the more radical social values of the 1960s and 1970s which opposed moral paternalism in any sphere. Valuing autonomy also reflected, Robert Veatch points out, the influence of Protestant theologians in the field. Protestantism, valuing as it does the power of the individual to reach truth unmediated, is more likely to emphasize individual freedom in such matters as direct access to medical information and decision-making power. It is an anti-paternalistic stance (Veatch, 1997, 13) that suited a society in which the physician was no longer an exalted being. Autonomy also occupies a hallowed position in American jurisprudence. The principle of self-determination and the right to privacy (in the U.S. Constitution) formed a basis for “the accumulating body of law about bioethical questions” (Jonsen, 1998, 335). Because American bioethics has dominated the field, American values have likewise been (perhaps grudgingly) accepted in more traditional societies. Stone and Matthews argue so forcefully for patient self-determination that one suspects that the British medical system has only recently yielded some power to the patients. Even as recently as 1985, the doctrine of informed consent was seen by British courts as a peculiarly American obsession (Schwartz and Grubb, August 1985, 19-25).

Autonomy alone is an insufficient value if human society is to be preserved. Autonomy

cannot be exercised in isolation but should lead to choices made by individuals in community (Darvall, 1993, 18). Recently, some bioethicists have pointed out that autonomy as a value tends to eclipse such communal values as altruism and beneficence (Darvall, 16). It is not, for example, an acceptable concept in cultures such as South-East Asia or in Amerindian cultures which value community over the individual.

Patients demonstrate their autonomy by turning to alternative medicine. Ironically, some may be so well-disposed towards alternative medicine that they let down their guard.

Non-maleficence

Non-maleficence demands that the physician not inflict harm on purpose (*Primum non nocere*). This could include inadvertent harm due to poor training or poor supervision. This is particularly applicable in the field of alternative medicine.¹⁸ Much of the discussion of this principle in bioethics surrounds issues such as withholding and withdrawing treatment and debates about what is proportionate or disproportionate treatment. Non-maleficence is similar to beneficence and some merge the two concepts into one principle. But obligations not to harm are different from obligations to provide benefits or to promote another's welfare. Beauchamp and Childress see the obligations of non-maleficence as stricter than those of beneficence. (Beauchamp and Childress, 1994, 189-193).

One might distinguish non-maleficence from beneficence in the following way: the

¹⁸Most medical errors are accidental. A disciplinary committee or court would look at whether the independent physician or healthcare team acted according to the "reasonable physician" standard. It is difficult to point to a reasonable standard in many forms of alternative medicine. However, acupuncture and chiropractic, as two examples, are sufficiently well-regulated to make it possible to create a "reasonable practitioner" standard.

beneficent physician should be aware of methods of alternative treatment that might ease a patient's suffering. Non-maleficence goes further. The physician should know what alternative remedies are harmful and ask, in his/her interview, if the patient uses alternative medicine (Sugarman and Burk, 1998, 1625). Non-maleficence may require that all who legislate for, recommend, or prescribe any form of medicine called "alternative", ensure that it is proven safe and efficacious and that those who provide alternative health-care be properly trained. Beneficence may require either that the law regulate complementary and alternative medicine or, in the view of those who think regulation will constrict the benefits of alternatives, leave it alone.

Beneficence

Beneficence is to act to further the welfare or happiness of another. Thomas A. Mappes and Jane S. Zembaty, in their text on bioethics, cite Kant who described beneficence as an imperfect duty as it does not require specific action. Kant considered beneficence to be inferior to other duties: "Action in the name of beneficence must never be taken at the expense of a perfect duty [such as refusing to lie or break a promise]... to save a third party from harm" (Kant in Mappes and Zembaty, 1991, 19-20). Beauchamp and Childress distinguish between *positive beneficence*, which requires the provision of benefits, and *utility* which "requires that benefits and drawbacks be balanced" (Beauchamp and Childress, 1994, 259). Utilitarianism is based on a principle of beneficence and David Hume, during the Scottish Enlightenment, made it the centre of "common-morality theory". It is a central human value -- an impulse towards altruistic regard and actions carried out for the benefit of others (Beauchamp and Childress, 1994, 260).

David Thomasma and Edmund Pellegrino have balanced autonomy with what they call

beneficence-in-trust. They suggest that occasions exist in which medical beneficence ought to prevail over patient autonomy (Darvall, 1993, 17-18).

The beneficence-in-trust model is closely related to virtue-based ethics. Virtue-based ethics imply that the practitioner him or herself must be sensitive to moral issues beyond a deontological or legal demand. Further, a virtue-based ethic puts a high value on the moral character of the practitioner. But Pellegrino and Thomasma say that this form of ethics “must be linked with rights and duty-based ethics” and that the stance of the practitioner must be made explicit in codes of ethics (Pellegrino and Thomasma, 1988, in Darvall, 1993, 18-19). They do not see virtue-based ethics as sufficient. Pellegrino and Thomasma say:

The more we yearn for ethical sensitivity, the less we lean on rights, duties, rules, and principles and the more on the character traits of the moral agent. Paradoxically, without rules, rights, and duties specifically spelled out, we cannot predict what form a particular person’s expression of virtue will take. In a pluralistic society, ...principles and professional standards ought to assume a dependable minimum level of moral conduct. But that minimum level is insufficient in the complex, often unpredictable circumstances of decision-making, where technical and value desiderata intersect so inextricably (Pellegrino and Thomasma, 1988, 21-22, cited in Darvall, 1993, 19).

W.D. Ross speaks of *prima facie* obligations versus the actual duties one faces in a specific situation. Beneficence is not only the expression of a utilitarian maxim to do good but an expression of charity. The duties of beneficence, according to Ross, are different from the duties of non-maleficence. Not injuring (non-maleficence) is distinct from making life better for individuals or society. One must not only prevent harm but do good. As Ross says, the recognition of the duty of non-maleficence is only the first step towards honouring the duty of beneficence (Introduction by editor and Ross, 1935, in Arthur, Ed., 1999, 42-46). While non-maleficence is, *prima facie*, more binding, physicians or health care practitioners who focus only on avoiding harm contribute little compared to colleagues who, through extra attention to the patient, or through research, actively seek out ways to improve the good of the individual and seek out improved cures for future patients.

Justice

Many different concepts of justice exist: for example, libertarian, liberal, utilitarian, liberationist. This thesis, however, will confine itself to the following categories. Justice can be divided into adjudicatory (this is the term used by Frederick B. Bird, 1999), or retributive justice, which refers to the way in which those who have been injured seek retribution or compensation; distributive justice, which is the equitable distribution of the goods of society and commutative justice which governs fair exchanges between people and is particularly relevant to the commercial aspects of complementary and alternative medicine.

Justice also contains several principles: one is formal and the other material. Aristotle is the originator of the theory of minimal or formal justice: “equals must be treated equally, and unequals must be treated unequally” (Beauchamp and Childress, 1994, 328). This principle is formal “because it states no particular respect in which equals ought to be treated equally and provides no criteria for determining whether two or more individuals are in fact equals. It merely asserts that whatever respects are under consideration as relevant, persons equal in those respects should be treated equally” (Beauchamp and Childress, 1994, 328). Material justice identifies what is to be distributed and offers principles to guide the way in which this exercise is performed.

The concept of adjudicatory or retributive justice will be discussed in chapter eleven with particular emphasis on ways in which society can handle wrongdoing in the field of complementary and alternative medicine through complaint systems, professional societies and the law. Justice is related to fair compensation. Stone and Matthews argue that alternative practitioners are responsible for proper regulatory and disciplinary procedures within their professions. Those who have been injured by alternative medicine must have a

way of making their dissatisfactions known and receiving compensation where required (Stone and Matthews, 268).

Theories of distributive justice have been developed: utilitarian theories which focus on maximizing utility of distribution of a good to the public; libertarian theories which focus on rights to fair procedures and to “social and economic liberty”; communitarian theories, emphasizing justice as it evolves through community traditions and egalitarian theories which stress “equal access to the goods in life that every rational person values” (Beauchamp and Childress, 1994, 334).

Alternative medicine is not equally available to all members of Canadian society. Unlike conventional medicine, it is not free and is, in practice, available only to those with sufficient money or insurance coverage. Stone and Matthews believe that alternative and complementary practitioners should look beyond their own personal concerns about official licencing and recognize that lack of equal access to alternative and complementary medicine is a legitimate problem in society (Stone and Matthews, 1996, 268).

Some issues specific to the commercial aspects of complementary and alternative medicine will be discussed under the category “commutative justice”. Concepts such as promise-keeping, truth-telling and avoiding conflicts of interest are germane to the discussion.

Methodology

All disciplines have a methodology. According to Jonsen, some people do not describe bioethics as a discipline. Daniel Callahan, in the 1973 article cited before, said “Bioethics is not yet a full discipline...[lacking] general acceptance, disciplinary standards, criteria of

excellence and clear pedagogical and evaluative norms” (Callahan, 1973, cited in Jonsen, 1998, 325).

Twenty-eight years later, can we describe bioethics as a discipline? A discipline has standards, criteria and can be taught. Since the mid nineteen-seventies, bioethics has been taught to medical and health care students. However, Jonsen says, “in the strictest sense,” bioethics “is not a discipline” as it has no “dominant methodology” or “master theory.” It borrows from theology the “secular remnant of the sanctity of the person.” From philosophy it has borrowed the “relatively recent division of ethical discourse into two normative theories, deontological and consequentialist, and the modern version of traditional contract theory” (Jonsen, 1998, 345). Jonsen calls bioethics a “demi-discipline” with one foot in the academy and the other in the “public discourse” of members of society discussing bioethical issues (Jonsen, 346). One could also say that it has one foot in the academy and one by the bedside.

Yet even if bioethics is a “demi-discipline”, it needs a method. Otherwise data cannot be organized, analyzed and applied. The early bioethicists were familiar with the methodologies of their own fields -- philosophy and theology. However, Jonsen says, even mid-twentieth century philosophers and theologians could not agree to accept one methodology. Over time, method came to assume a more prominent place in bioethics (Jonsen, 1998, 339-342). The need for method became acute as bioethics began to be taught and Jonsen suggests two: one for “scholarly inquiry” and another for teaching its results (Jonsen, 340).

Methodologies devised by various ethicists include David Thomasma’s “ethical work-up”, a six- step way of “identifying underlying ethical norms in a case” (Jonsen, 1998, 341). This is a common way of teaching medical students as is the casuist method proposed by

Jonsen and his colleague Stephen Toulmin. It is a particularly useful method when dealing with specific dilemmas at the bedside such as decisions about withholding fluids and nutrition from dying patients.

James Gustafson proposed a method in which important issues of a case were stated, “conflicting propositions directed to each” and then developed so as to shed light on the “contrasting judgments” (Jonsen, 1998, 340). In 1976, Samuel Gorovitz and his colleagues at Case-Western Reserve University wrote *Moral Problems in Medicine* which combined relevant writings from philosophers such as Kant with specific bioethical problems. In this way, theory could be applied to practice (Jonsen, 340). Howard Brody’s *Ethical Decisions in Medicine* (1976) offered a technique in which cases are presented, followed by the consequences of different actions. These consequences are compared to values held by the student physicians (Jonsen, 341).

Methodology continued to be a concern up through the 1980’s. Arthur Caplan thought Beauchamp and Childress’ and Veatch’s approach was “the engineering model of medical ethics” in which, as in engineering, it is presumed that theory can simply be “applied” to a problem (Jonsen, 1998, 342).¹⁹

Other approaches focused on physicians’ responsibilities and virtues and feminist, ethnic and deconstructionist approaches to ethics joined the list of methodologies. Jonsen also spoke of “Federal ethics”, the public moral discourse by the federal state and other

¹⁹Jonsen was citing Laurence B. McCullough, “Methodological Concerns in bioethics”, *Journal of Medicine and Philosophy*, 11, (1986) (17-37) 33-34 in Arthur L. Caplan “Applying Morality to advances in biomedicine: Can and Should this be done?” in William B. Bondeson, H. Tristram Engelhardt, Jr., Stuart F. Spicker and Joseph M. White, Jr (Eds.) 1982, 155-168, *New Knowledge in the Biomedical Sciences: Some Moral Implications of its Acquisition, Possession, and Use*.

government bodies and professional and institutional forums (Jonsen, 1998, 342).

The methodology most in tune with the four-principles theory is the application of the principles to specific practices. For the purposes of this thesis, the four principles will be four lenses through which each issue will be viewed. It will be useful to see whether the application of the four-principles theory to alternative medicine will expose ethical dilemmas unique to its field.

Conclusion

The May/June 1993 issue of *Hospital Ethics* suggested that bioethicists may have an important role to play in collaboration between conventional and alternative bioethics as they share with alternative medical practice a focus on the importance of humane care and joint decision-making between care-giver and patient. The authors suggest that the practice of bioethics itself may help to connect the two types of medical practice which are traditionally hostile to one another (see *Unconventional therapies vie for professional acceptance*, 1993, May/June, 6-7). Alternative practitioners, for example, have much to teach conventional doctors about communication and care (Buckman, 1993, 100-118). Bioethicists may be able to work with governments and associations of alternative practitioners to determine how best to protect the consumers of alternative medicine while at the same time acting as “shuttle diplomats” (Ziegenfuss, 1988) bringing some of the wisdom they may have acquired in the field of conventional medicine to alternative practitioners who are engaged in designing clinical trials or codes of ethics. The bioethicists may bring back to conventional medicine a more profound understanding of the deep fears and need for meaning that all people who are ill seek when they turn to a healer. This is a task ethicists must approach with care, knowing that there is much to learn about human behavior and moral choice and judgement from even the most arcane alternative practice.

A difficulty in discussions about alternative medicine is defining what it is. This will be the topic of the next chapter.

Part Two

Complementary and Alternative Medicine: Practice, Practitioners and Consumers

Part Two - Introduction

Complementary and Alternative Medicine: Practice, Practitioners and Consumers

An advertisement posted on the employee bulletin board of a Montreal teaching hospital said the following:

If you are looking for products to help reduce stress and promote better health and give you energy then this is for you! These products help restore the balance in our body by earth's natural energy (Magnetic, far infrared (sun's energy), and bio-directed nutrients).

....

With our failing health care system we have to look at alternatives to maintain and/or improve our health. This is the answer! (Advertisement for Nikken Wellness Technology for Living, posted May 15, 2000).

Who wouldn't want to reduce stress and increase energy? The harassed hospital worker, preparing to go home after yet another day in a "failing health care system", might find the appeal of this advertisement (faintly reminiscent of the lurid patent medicine advertisements of the nineteenth century) sufficiently enticing to make a telephoned inquiry.

The field of complementary and alternative medicine is vast. Hundreds of practices and practitioners could probably be grouped under the seven major categories developed by the American National Institutes of Health National Center for Complementary Medicine. To put some order into this field, chapter three will discuss the various ways in which complementary and alternative medicine has been defined and classified and chapter four will try to answer the question so many conventional medical professionals ask: "why do people use it when they could go to officially licenced doctors, receive accurate diagnoses and rigorously tested and approved treatments?"

Chapter Three

What is Complementary and Alternative Medicine?

Introduction

In *The Birth of the Clinic*, Michel Foucault spoke of the “benevolent ‘gaze’” of the family caring for the sick person at home (Foucault, 1963/1975, 40) and its replacement with the “clinical ‘gaze’” in which the patient became an object of observation, detached from his or her natural surroundings. The natural setting came to be seen as extrinsic to the illness (Foucault, 109-110) and the patient was observed “in the same way that we observe the stars or a laboratory experiment” (Sourniu, 1962, in Foucault, xv).

The philosopher Michel de Certeau, discussing Foucault’s work, says that:

A society is...composed of certain foregrounded practices organizing its normative institutions *and* of innumerable other practices that remain ‘minor,’ always there but not organizing discourses and preserving the beginnings or remains of different (institutional, scientific) hypotheses for that society or for others (de Certeau, 1984, 48).

Modern biomedicine could be viewed as a foregrounded practice which organizes such normative institutions as hospitals. The field of health care and healing also includes other, “minor” practices. de Certeau goes on to say that “beneath the ‘monotheistic’ privilege that panoptic apparatuses [a reference to Jeremy Bentham’s Panopticon, an architectural design which enabled warders, hospital staff and schoolmasters to “gaze” at prisoners, patients or schoolchildren from afar (see Foucault, 1975/1977, 200)] have won for themselves, a ‘polytheism’ of scattered practices survives, dominated but not erased by the triumphal success of one of their number.” de Certeau says that certain “minor” practices have not been “‘privileged’ by history.” They do not have “*their own place (un lieu*

propre) on which the panoptic machinery can operate” (de Certeau, 1984, 48-49).

We could see many alternative practices as “minor” and not privileged by history. Some alternative practices such as homeopathy, chiropractic and osteopathy were developed in the eighteenth and nineteenth centuries and, as practiced today, can be quite “medical” in form. They have not, however, been “privileged” by history. Other practices, such as herbalism based on astrology (propitious times for harvesting herbs according to astrological signs), crystal healing or psychic healing, seem to be a preservation of the remains of different hypotheses about the human body, health and illness (see de Certeau, 1984, 47-50). These are practices that were “*displaced* by the medical ‘gaze’ that was supposedly ushered into being at the end of the eighteenth century” (Cooter, 1988, p. 63).

In the *Birth of the Clinic*, Foucault suggested that we are only now beginning to disentangle the threads of structures that seem both new and archaic (Foucault, 1963/1975, 199). Older ways of seeing have been forgotten. This was an advantage to the economic system. Cooter describes this development as the “unstated positivist metaphysic [which] assumes the fragmentation and reification of all things -- including, above all, human beings” (Cooter, 1988, 63). The forgotten ways of seeing are a challenge to medical monotheism.

The term “alternative medicine” is used to encompass a wide range of practices. This alone might seem to put in question a number of studies which claim that its use is increasing. What is included and what is not included in a taxonomy of alternative medicine is important to any study of the extent of its practice. For example, as noted in chapter one, the landmark study conducted by Eisenberg and his colleagues in 1990 (Eisenberg, et al., 1993) includes prayer and dietary manipulation in its list. If these two practices are included, much of the North American population could be said to have tried some form of alternative

medicine at least once. Eisenberg included all interventions not widely taught or used in U.S. medical schools or hospitals although this way of categorizing alternative medicine is constantly changing as medical schools introduce courses in the subject. Furnham points out that when exercise and relaxation methods are included in studies of the use of alternative medicine, the results “exaggerate the use of truly unconventional therapies...” However, he says, the studies still show that, rather than slowly disappearing in the face of advances in conventional medicine, the use of alternative therapies is increasing (Furnham, 1996, 73).

Many practices of alternative medicine listed in the Eisenberg study are not based on principles known to modern Western science. Edward Campion, MD, in an editorial in the *New England Journal of Medicine*, noted that a third of the unconventional practices “entail theories that are patently unscientific and in direct competition with conventional medicine....” He lists these competitors: chiropractic, spiritual healing, herbal medicine, energy healing with crystals or machines, homeopathy and acupuncture, and concludes that their use should lead conventional physicians to worry about their effectiveness in dealing with the whole patient (Campion, 1993, 282-283).

The notion of alternative medicine needs to be relative rather than absolute as what is alternative is not fixed in time but shifts from century to century and from culture to culture. Saks points out that whereas in Great Britain, the concept of alternative medicine is holistic, emphasizing the life force of the individual in contrast to the more mechanistic view of biomedicine, much of alternative medicine in Great Britain has links with mainstream healing practices of earlier centuries and may become “at least part of the new orthodoxy of the future” (Saks, 1992, 4). Saks points to Wright’s analysis of the decline of astrology in medicine in the seventeenth century and says that “the definition of the boundaries of

alternative medicine is not simply based on the adequacy, or otherwise, of the knowledge involved. Rather, it is a social creation, contingent in large part on relationships of power” (Saks, 11). This is consonant with the views of Kleinman (1983); McGuire (1988); and Fulder (1996).

The authors of a work on holism in biomedicine say that alternative medicine became popular between 1920 and 1950 and had an influence on holistic perspectives in biomedicine in some countries. The authors point out that, in the interwar years, orthodox medical practitioners and researchers were engaged in various attempts to maintain medicine’s emphasis on the whole person. This was a reaction to the increasing mechanistic and reductionistic movements in modern society and modern science. They suggest that late twentieth century interest in alternative medicine was influenced by interwar holism (Lawrence and Weisz, 1998, 1-22, particularly page 16).

Terminology

Much debate has taken place over labelling medical and healing practices outside the biomedical mainstream as alternative or complementary. The terminology used to describe these practices often reflects the acceptance or non-acceptance of this type of healing as medicine. The National Center for Complementary and Alternative Medicine offers the following definitions. Using the acronym CAM, it says complementary and alternative medicine could be “defined as those treatments and healthcare practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies” (<http://nccam.nih.gov/nccam/fcp/faq./index.html>). This is a somewhat vague definition as insurance companies are increasingly reimbursing alternative therapies and some are actively used in hospitals. NCCAM notes that some use the term “holistic”, to describe alternative practice, meaning that the therapist focuses on the whole

person. However, this implies that conventional doctors treat people in bits and pieces (e.g. “the breast in room 180, the kidney coming out of surgery now.”). Others like the term “preventive” to underline the fact that the practitioner of CAM helps the client to protect his or her health.

Saks prefers the term “alternative”. He says that the labels “traditional medicine”, “complementary medicine” and “holistic medicine” have been applied to practices like acupuncture, herbalism, homeopathy and spiritual healing. But alternative medicine is the central organizing concept. “The competing concepts...are insufficiently comprehensive for the purposes intended.” For example, the term “traditional medicine” might be applied to the ancient practice of laying on of hands and classical acupuncture but does not include the more recently founded (nineteenth century) practice of chiropractic. “...for all the ideological capital unorthodox practitioners may derive from co-operating with the medical establishment, the label of ‘complementary medicine’ excludes therapies like homeopathy which, in their purest form, are based on philosophies that fundamentally conflict with medical orthodoxy” (Saks, 1992, 3). He adds that the fashionable term “holistic medicine” applies to homeopathy but rules out osteopathy with its mechanistic approach to disorders. The term “alternative medicine”, he says, is “more all-embracing” and more analytically useful because it does not focus on looking for similarities in therapies which are extremely diverse. Alternative practices are heterogeneous. All they have in common (their “key distinguishing feature”) is their “socio-politically defined marginal standing in the health care system” (Saks, 1992, 3).

Saks’ definition of alternative medicine includes all health care that functions outside the official system. Alternative medicine is that which is excluded from the medical curriculum, is not seriously reviewed in mainstream journals and receives no orthodox research funding

(Saks 1992, 4). The definition is now dated in that the NIH NCCAM is an orthodox funding agency and complementary and alternative medicine studies have been reviewed in such mainstream journals as the *Journal of the American Medical Association*.

In 1996, a group working under the aegis of the former Office of Alternative Medicine (now NCCAM) classified alternative medicine as “an unrelated group of non-orthodox therapeutic practices, often with explanatory systems that do not follow conventional biomedical explanations.” This was an advance over their earlier classification which described it as “non-orthodox therapeutic systems that have no satisfactory scientific explanation for their effectiveness” (Alternative Medicine: The challenge, 1999, September, 10).

The *Office des professions du Québec* (août 1991) describes alternative medicine as that which uses no surgery and no or very few chemical substances. But what is alternative medicine alternative to? One only has an alternative if something else is accepted as standard or conventional. The *Office des professions* described alternative medicine as alternative to the professional system, alternative to modern scientific medicine and alternative to the services offered under medicare. Many of the official responses to alternative medicine describe it as being based on intuitive knowledge and experience rather than the rules and laws of professional health care (*Office des professions*, août 1991, 2. 3., 8). In French it is often called “*médecine douce*” or gentle medicine.

Other terms used are “integrative medicine”, “unconventional medicine”, “natural medicine”, or “*médecine parallèle*”. Each has its problems. Integrative medicine can only be used when the practice is integrated with conventional medicine into a total care plan. Once it is accepted by orthodox physicians, the term unconventional no longer applies.

Natural medicine implies that conventional medicine is not only unnatural but that it is mechanistic and uses only chemicals. Yet even conventional practice may recommend such natural means as diet or relaxation exercises. The term “*médecine parallèle*” implies an equality with conventional medicine that many physicians would reject.

According to Ruth West, if the definition “alternative medicine” causes problems, the practices we classify as alternative only make the problems more complex. One can include all health care which functions outside the parameters of official health care but this would place Christian Science healers, medicine men, and Ayurvedic practitioners on the same level (West, 1984/ 1992, 201-202). Since 1992 (when Saks’ book, in which West’s article appeared, was published), many alternative practices have received more sympathetic treatment from the medical establishment (see works by Lewith, Kenyon and Lewis, 1996; Ernst, 1996; Jonas and Levin, 1999). Lewith, Kenyon and Lewis and Ernst, incidentally, use the term complementary medicine in the titles of their books as if the term were self-explanatory. While “complementary medicine” appears to be the common term in Great Britain, judging from the titles of recently published books on the subject, North American usage is tending more and more towards complementary and alternative medicine, often referred to as CAM.

Following is a more detailed discussion of the various names used for this type of medicine:

“Complementary”, “integrative” or “alternative”

The term complementary medicine is not a new or more fashionable way of describing alternative medicine. But when is alternative medicine complementary? We can look at how it is applied by the practitioner or institution and how it is used by the consumer. If an individual physician integrates alternative medicine into her conventional practice, we might

describe the person as a practitioner of integrative medicine. If a hospital offers a few alternative modalities that patients are free to accept or reject, such as massage therapy or aromatherapy, these practices complement conventional practice but they are not integrated into the system. One might properly call them complementary therapies. The term “complementary medicine” is also used by some alternative practitioners who wish to be seen to cooperate with the medical establishment and prefer to be called practitioners of complementary or supplementary medicine. Consumers who have the good fortune to work with a doctor open to both types of medicine are integrating their health care under the guidance of one practitioner. More commonly, the term complementary medicine is used to describe consumers who use both forms of medicine when seeking cure. Very rarely, as we will see in the next chapter, do consumers use alternative medicine as a true alternative to the conventional system.

The U.S.National Center for Complementary and Alternative Medicine distinguishes between alternative and complementary medicine by saying that some describe treatments used alone or in combination with other alternative therapies as alternative and those used alongside conventional therapies as complementary (<http://nccam.nih.gov/nccam/fcp/faq/index.html>).

The Tzu Chi Institute of Vancouver, which conducts alternative medical research, believes that labels like “complementary” or “alternative” will become unnecessary as “all relevant, safe and effective healing practices become part of one, comprehensive healthcare system” (<http://www.tzu-chi.bc.ca/faq.htm>).

Fulder uses the term complementary medicine noting that boundaries are shifting with the increasing union of conventional and unconventional medical interests. While the

philosophies of certain types of healing do not fit conventional medical models, the base of osteopathy is “quasi-scientific” and closer to orthodox medicine (Fulder, 1996, 3). The term “complementary medicine” he says depicts these healing methods as different from but in partnership with scientific medicine. Fulder feels complementary medicine is the correct term as society moves towards “medical pluralism” (Fulder, 1996, 3). This seems to be an excessively sanguine use of the term complementary medicine. Used in this way, the term is politically loaded as it assumes a very different form of medicine in the future. Fulder rejects the terms “fringe”, “unorthodox”, “unconventional” as out of date (Fulder, 3). Biomedical professionals interested in alternative therapies would probably find such terms inaccurate and pejorative.

Many people use alternative medicine as an adjunct, not as a primary mode of cure. The sociologist Meredith McGuire found that the people she studied often went to a conventional physician for diagnosis and an alternative practitioner for cure (McGuire, 1988, 193-195, 146). This desire for choice is, perhaps, a reflection of current religious behavior. As sociologist of religion Reginald Bibby pointed out in his book *Fragmented Gods* (1987), Canadians behave like consumers of religion, picking and choosing what suits them in the spiritual supermarket (Bibby, 1987, 146-148). The Sunday Massgoer may consult a fortune-teller to make decisions about the future, unaware that this is clearly forbidden (The Catholic Catechism, 1994, 2110-2117) or engage in Buddhist prayer practices; a Protestant might visit a miraculous, and unapproved, shrine for healing.

Conventional versus alternative

Dichotomies exist in the use of the terms conventional and alternative medicine. Roger Cooter, in *Alternative Medicine, Alternative Cosmology*, points out that practices described as heterodox in the nineteenth century, such as homeopathy, hydropathy, mesmerism and

botanic medicine, were not necessarily understood to be conceptually different from orthodox medicine. They may have been labelled heterodox because their methods were different from the types of medicine that hoped to join the ranks of scientific medicine. They may simply have been viewed as inadequate, compared to what appeared to be more scientific medical practice (Cooter, 1988, 64). Many of these types of medicine were based on vitalist theory: the belief that all living organisms contain a type of energy which cannot be explained by mechanistic science. This idea goes back to Aristotle's principle of entelechy (Holroyd, 1989, 30) and was implicit in the development of many forms of alternative medicine. Vitalism was a perfectly orthodox theory in the eighteenth century. Nineteenth century heterodoxy was a continuation of eighteenth century orthodoxy (Cooter, 70). "To a large extent, therefore, the vitalism of the early nineteenth century heterodox medicines can be seen merely as a continuation of ideas well entrenched in 'orthodoxy' only shortly before, and which, indeed, continued to find an outlet in the writings of the medical establishment." It did not exist "as a tidy antithesis to positivist medicine" because the categories overlapped (Cooter, 71,70). In this sense, alternative medicine is not new but can be seen as a fragment of the past enduring in the present. Many of today's heresies are yesterday's orthodoxies.²⁰

In spite of the debates about terminology, this thesis will use the term commonly used by academic medical centres and an increasing number of medical journals -- complementary and alternative medicine, shortened to CAM.

²⁰Miley and Pickstone (*Medical Botany around 1850*) note that one would be incorrect in thinking that those described as being on the fringe of medicine were "strongly set against orthodoxy". Homeopathy is but one example of a medical method practiced by "regulars" as well as populists (Miley and Pickstone, 1988, 144), a position it occupies today. Just as priests may engage in "magical" or popular religious practices, so too do some conventional physicians practice heterodox medicine.

Types of Complementary and Alternative Medicine

The field of alternative medicine is vast and difficult to organize. One should not, in fact, speak of alternative medicine but alternative medicines. Many taxonomies of alternative medical practices exist. For example, the U.S. National Center for Complementary and Alternative Medicine breaks down practices into the following categories: (1) mind-body medicine which includes behavioral, psychological and spiritual approaches to health; (2) alternative medical systems such as acupuncture and oriental medicine or unconventional Western systems; (3) lifestyle and disease prevention; (4) biologically-based therapies such as herbalism, special diet therapies, including the subcategory orthomolecular medicine; (5) manipulative and body-based systems; (6) biofield or energy medicine, which uses subtle energy fields for healing; (7) bioelectromagnetics, which involves the unconventional use of electromagnetic fields (<http://nccam.nih.gov/nccam/fcp/classify.shtml>).

Because the NCCAM is the main North American granting agency for alternative medicine studies it developed this taxonomy as a guide for people submitting research proposals. The categories also make it easier to rank research grant applications. Such a taxonomy is not helpful to clients, however, and categories overlap, as they point out. They classify some of the practices of conventional medicine, such as biofeedback, as behavioral medicine, a subcategory of mind-body medicine. As noted before, depending on how they are applied, some modalities can be complementary or conventional (<http://nccam.nih.gov/nccam/fcp/classify.shtml>).

Potential clients of complementary or alternative medicine may seek out a specific method because they have read about it, seen an advertisement, or because a friend has recommended a product or practice. Some doctors may also want to know what sort of alternative practice could be helpful to a patient. Those who actually want to use a CAM

may find other taxonomies yield more information about the general classification under which the specific modality is listed.

Following are various attempts to bring order into this hugely variegated field, indicating how the different practices are to be applied and the level of training required. Unlike the NCCAM taxonomy, these classifications can serve to guide the professional and lay public in choosing an appropriately trained practitioner and a practice well-matched to the needs of the client.

The Taxonomy of Patrick Pietroni and the British Medical Association

Patrick Pietroni's taxonomy is found in his *The Greening of Medicine* and was used by the British Medical Association in its report *Complementary medicine -- new approaches to good practice*, published in 1993 by Oxford University Press (Stone and Matthews, 1996, 87). His fourfold taxonomy includes:

(1) Complete systems of healing which include "traditional Chinese medicine, herbal medicine, osteopathy, chiropractic, homeopathy, and naturopathy." These systems are described as complete because they are grounded in theories which explain the causes of disease and they are comprehensive in a way that other alternative therapies are not. Stone and Matthews cite Pietroni: "They have a diagnostic, investigative and therapeutic understanding which share some similarities with orthodox medicine" (Pietroni, 180, in Stone and Matthews, 1996, 87). The British Medical Association describes these therapies as "discrete clinical disciplines" as they are not complete in the way that orthodox medicine is. However, they are complete within the alternative field. They are systems that require extensive training and also have the potential to harm (Stone and Matthews, 87-88). Complete alternative systems of medicine exist in other cultures: Ayurvedic and Chinese

medicine, for example, are deemed alternative in Western culture but are either orthodox or complementary in India and China.

(2) Diagnostic methods such as iridology, kinesiology, dowsing (using rods and pendulums to diagnose) and reading auras (Stone and Matthews, 1996, 88).

(3) Therapeutic modalities such as reflexology, spiritual healing or massage. These practices are applied to create a therapeutic effect rather than to diagnose (Stone and Matthews, 1996, 88).

(4) Self-help methods such as yoga, tai chi, meditation, guided visualization (Stone and Matthews, 1996, 88).

Evaluation of Pietroni's taxonomy

Strengths: The classification system is tidy but broad enough to allow room for most therapies.

Weaknesses: The very compactness of this classification means types of therapies are oversimplified to fit and are reduced to whether or not they are used to diagnose or to be therapeutic. There is no category for the paranormal, under which some might classify dowsing and reading auras. The self-help category includes methods that often require a leader or facilitator or are part of a large group. For example, guided visualization is often taught by psychologists and yoga, tai chi and meditation might be part of a larger movement properly called religious or spiritual.

Stone and Matthews' Taxonomy

Stone and Matthews value Pietroni's four-fold schema for its focus on the therapeutic aspects of complementary and alternative medicine. Their work is focused on the regulation of alternative medicine, hence they offer a two-tiered division which divides therapies into those which are closer to orthodox medicine, and thus need similar regulation, from those which are more innocuous. They believe that the systems described as "complete" will come under increasing scrutiny as they compete with orthodox medicine. These systems claim to diagnose and treat many disorders and are therefore "seen as a greater philosophical and professional threat to the orthodox profession and hence will be under significant pressure to substantiate ...[their] claims" (Stone and Matthews, 1996, 89). They are also seen as potentially dangerous (Stone and Matthews, 88), either because they lead people to avoid conventional cures or use methods that pose risks.

Stone and Matthews describe a way of classifying alternative medicine that is designed to help those responsible for regulating it. Regulators may determine that a practice -- naturopathy for example -- is a complete system of healing and needs strict regulation (see Stone and Matthews, 1996, 89). To decide which practices need stringent regulations and those that do not, they suggest that practices be looked at in the following terms:

(1) Are they complete systems, which are best protected by government regulations and registration (Stone and Matthews, 1996, 89)?

(2) What is their "mode of intervention"? If the intervention is similar to that of orthodox medicine, then similar regulations may be needed (Stone and Matthews, 1996, 90).

(3) Could they cause harm, either directly, because the practitioner is poorly trained or

indirectly, because the patient may avoid conventional medicine (Stone and Matthews, 1996, 90)? This would include chiropractic, osteopathy or prescriptions for diets or herbal or homeopathic remedies.

(4) What degree of therapeutic skill is needed? Some practitioners rely on intuition or even an inherited gift. However, any therapy claiming to heal will have to justify a standard based on knowledge (Stone and Matthews, 1996, 92).

(5) Is the therapy validated by science? Orthodox medicine usually demands that therapies prove that they are efficacious and safe through research trials. However, governments do not always place so high a priority on scientific validation. Stone and Matthews say that when 25% of a given population uses complementary and alternative therapies, insisting on validating therapies scientifically can detract from what they consider to be a more important need to focus on the issue of educational standards. However, unless alternative therapies can prove themselves through scientific research, they will not be taken seriously by conventional medicine (Stone and Matthews, 1996, 92- 93). Conventional physicians and medical institutions cannot easily recommend or practice alternative therapies with no scientific proof because such a practice flies in the face of the standards of conventional, evidence-based medicine.

(6) Can the practitioners be tested on measurable skills and results? If an alternative therapy requires the practitioner to offer medications or invade the body, then this practice can be measured. If skill in these practices is acquired through extensive study, the level of knowledge and skill can be tested. Stone and Matthews think that alternative practices with these characteristics will be tested and measured, “possibly at the expense of more ‘*humanistic*’ skills.” They suggest that such therapies will start to rely on that which can be

measured and validated, just as orthodox medicine does (Stone and Matthews, 1996, 93).

(7) How long has the alternative practice been established? Some alternative practices, most notably herbalism or (in the East) acupuncture, are very ancient. Other, like homeopathy, are only about 200 years old and some, such as naturopathy, though based on much older ideas, are only 100 years old. Stone and Matthews believe that the way in which the alternative specialty is organized is more important than how old the system is (Stone and Matthews, 1996, 93-94).

(8) To what extent are doctors interested in the alternative method? Stone and Matthews point out that though homeopathy is based on theories incompatible with modern science, it is so close in practice to conventional medicine that many of its practitioners are physicians. When physicians practice an alternative therapy, they may object to its practice by laypeople (Stone and Matthews, 1996, 94). Conversely, lay practitioners of homeopathy and acupuncture may resent physicians trying to regulate the field, arguing that physicians do not take a holistic approach but apply remedies as if they were conventional drugs or interventions. Such arguments, Stone and Matthews point out, will probably not arise in the practice of aromatherapy as physicians are unlikely to be interested (Stone and Matthews, 94).

(9) Is the practice seen as credible? Stone and Matthews state that many factors, of which scientific proof is only one, determine whether an alternative practice is seen to be credible. While doctors might think that a practice is only credible if proven, Therapeutic Touch has gained credibility because of its extensive practice by nurses. Aromatherapy and reflexology, also practiced by nurses (often in palliative care settings), are also examples of practices gaining credibility in the health-care professions allied to conventional medicine

(Stone and Matthews, 1996, 94-95).

Evaluation of Stone and Matthews' taxonomy

Strengths: Stone and Matthews' schema offers several advantages: by distinguishing those therapies closest to conventional medicine from those designed to create a healing effect (both applied by a practitioner and self-help methods), they make it possible for the potential consumer, or referring physician, to be aware of the levels of training they should expect from the practitioner. They also clearly distinguish between practices that harm and those, like aromatherapy, that are usually safe. Their taxonomy is useful for legislators.

Weaknesses: The disadvantage of this taxonomy is that it does not distinguish between systems with a spiritual/metaphysical base and those that are more "scientific". Stone and Matthews list medical dowsing and aura diagnoses under diagnostic methods but do not further subdivide these practices under a category that could be called "occult". Medical dowsing is a form of divination with no studies to support its medical use (Woodham and Peters, 1997, 198) and aura diagnoses are grounded in a paranormal belief that negative and positive energies can be seen by a specially gifted "seer".

Ruth West's Taxonomy

Ruth West says that one can use the definition of the World Health Organization and describe alternative medicine as all health care outside that which is official. In the UK, she says, medicine outside the mainstream would include about sixty therapies. Using this framework, West divides therapies into the physical, psychological, and paranormal. She says one could include in physical therapies naturopathy, herbal medicine, manipulative therapies like chiropractic, Alexander technique and reflexology, exercise/movement like yoga and dance and art therapy (not all would call these alternative), homeopathy,

anthroposophical medicine. Primal work and encounter could be categorized as psychological therapies; radionics, exorcism and hand healing as paranormal therapies and palmistry and iridology as paranormal diagnostic methods (some iridologists might object to this, claiming that inspecting the iris of the eye is scientific). The problem with this sort of taxonomy, West points out, is that the alternatives are “like the contents of a dustbin.” Some might be rescued and recycled if they are of value; much should stay in the refuse bin, waiting to be hauled away (West, 1984/ 1992, 202).

West, like Stone and Matthews, suggests another categorization: therapies which require a high level of professional training and skill and those that are closer to first-aid or self-help. She places acupuncture, osteopathy, homeopathy, medical herbalism and nutritional therapies in the first category. In the second category -- variations of first-aid or self-care -- she places most other therapies except those which offer psychotherapy. She suggests that methods with high-level training requirements could join forces with conventional medicine and the others could join those professions supplementary to medicine (allied health care professionals) (West, 1984/1992, 202-203). However, allied health care professionals such as physiotherapists or dietitians could hardly be equated with practitioners of first aid.

Evaluation of West's taxonomy

Strengths: This division may guide government organizations trying to determine how to legislate for alternative medicine. Ruth West suggests a category for the paranormal although, as noted, iridologists believe their method is based on science. West's taxonomy may be useful for those who must determine minimal training levels and requirements for licencing.

Weaknesses: Dividing therapies into two types -- those requiring high levels of skill and

training and those that do not -- may prove difficult. West suggests that all therapies not requiring high levels of training, save some psychotherapies, could be placed together. Yet, while chiropractic or homeopathy clearly require much higher levels of training than aromatherapy, the paranormal techniques West initially classifies as separate from physical and psychological therapies require high level training of another order -- responsible use of paranormal powers -- as these techniques do not use methods known to science nor are they self-help first aid. I would suggest a third category for all paranormal therapies as some pose the danger of excessive attachment to a spiritual leader (thus attenuating free consent) and may be felt by some to be spiritually harmful.

Practices Tested by Clinical Trials versus those Based on a History of Unproven Efficacy, Intuition and Paranormal Abilities

One could distinguish between alternative medical practices which have been tested by clinical trials and those that are based on historical efficacy (without proof), intuition, or paranormal abilities. British doctors Lewith, Kenyon and Lewis have gathered together some common diseases and listed all the alternative cures which have been tested, rating them according to efficacy (LeWITH, Kenyon, Lewis, 1996). Clinical trials are the gold-standard for modern, evidence-based medicine. Yet many remedies in conventional medicine, the most notable example being aspirin, have not been proven in clinical trials. However, the client should know what has been tested and proven and what has not. Although it requires even more sophistication, one should be able to assess the scientific validity of the trials. The work of Bernard Grad on wound healing in mice through the transfer of healing power and that of Jacques Benveniste, who claimed that water could “remember” the healing substances placed in it and retain the healing power²¹, are often

²¹Benveniste's controversial research claimed that homeopathy had an effect on cellular activity. A white blood cell was isolated and submitted to exposure to immunoglobulin E antiserum in a homeopathic dilution. This blood cell released histamin.

cited to prove the efficacy of healing by the transfer of energy to an object or cure through homeopathic remedies. Many, even some practitioners of alternative medicine, find these studies to be questionable (Varro Tyler, in Knight, 1999, Sept/Oct, 47). However, Adriane Fugh-Berman, MD, in her assessment of clinical trials in alternative medicine, criticizes those who negatively evaluated Benveniste's research trials. The rejection of Benveniste's claims, she says, were based on a shoddy assessment. She points out that the so-called experts who rejected Benveniste's claims included a magician, a journalist and an expert in fraud. They visited Benveniste's laboratory and conducted one blind study using two blood samples in poor condition that did not support the results published in *Nature* (Fugh-Berman, 1997, 134-135).

Evaluation of treatments submitted to clinical trials versus untested treatments

Strengths: In the final decade of the twentieth century, physicians' concern with the growing popular attraction of alternative medicine led to the demand for proof via clinical trials. While recognizing that the results of some clinical trials are more compelling than those of others, most physicians and many consumers feel more confident when provided with proof of safety and efficacy. From that point of view, such a distinction has merit.

While this would be the expected result of white blood cell exposure to immunoglobulin E antiserum, mainstream scientists were amazed to read that an extreme homeopathic dilution would have the same effect because the homeopathic version did not contain any molecules of the antibody (Fugh-Berman, 1997, 134). The June 1988 issue of *Nature* contained an editorial caveat: "There is no objective explanation of the observations," the editorialist said, adding that it would be "premature, probably mistaken" to use Benveniste's research to support the principles of homeopathy. The editorial concluded by asking the reader to analyze Benveniste's findings with greater care than usual because they contradicted 200 years of scientific thought (When to believe the unbelievable [editorial], 1988, June 30, 787). To further emphasize the point, the editor opined, at the end of Benveniste's article, that readers might be as disbelieving as the pre-publication reviewers. Benveniste and his colleagues, as well as the editor, were unable to explain how water could retain the ability to "evoke a biological response" when there was little or no chance of any molecules of the antibody remaining in the highly diluted preparation (Editorial reservation, 1988, June 30, 818). The journal editors later collaborated with Professor Benveniste and arranged to have the experiment replicated.

Weaknesses: Not all alternative methods need to be proven through clinical trials and many are ill-adapted to them. For example, any therapy that relies on highly subjective elements such as a powerful belief in the method or the practitioner, or on multiple variables, such as the prescription of homeopathic remedies based on the client's food and temperature preferences, will be difficult to measure. However, the same may be said of conventional treatments if the patient's belief in the medicine or the practitioner is overwhelmingly strong. The increased interest of conventional medicine in studying alternatives may lead to the unfortunate presumption that all untested methods are intrinsically suspect or of little value. As biomedicine co-opts alternative methods, the demand that only researched and proven therapies be offered will be the inevitable result. Many alternatives might simply join the sub-specialties of conventional medicine. Society may then face a situation very similar to that which occurred at the beginning of the twentieth century. All methods deemed acceptable by science will be taught and practiced in the official biomedical system and an array of formerly alternative practices will be available. If conventional medicine co-opts all alternatives it deems suitable, the genuine alternative field will be unregulated and unlicensed. In this admittedly dystopic view, the future of complementary and alternative medicine is a future in which the weaker is swallowed whole by the stronger.

Meredith McGuire's Taxonomy

Meredith McGuire divides alternative healing into the following categories: Christian; metaphysical; Eastern meditation and human potential; psychic and occult, and the work of technique practitioners (homeopaths, osteopaths) (McGuire, 1988). In this classification system, the client has some idea of which group is accountable and which not and will know which is based on spiritual beliefs and which has jettisoned this aspect (for example, homeopathy, osteopathy, chiropractic have largely moved away from the metaphysical beliefs of their founders). This last point is important for those who believe in and fear

spiritual dangers from, for example, practices like spiritualism.

Evaluation of McGuire's taxonomy

Strengths: McGuire's taxonomy recognizes what the others do not -- some methods are intrinsically spiritual or religious, but in different ways. McGuire makes these finer distinctions.

Weaknesses: McGuire's divisions do not take into account training requirements, the need for government approval. However, this is not the intention of her work and these aspects are adequately covered by other scholars.

The Author's Taxonomy

Following is a taxonomy developed by the author based on readings in West (1984/1992), McGuire (1988), Fuller (1989), Fulder (1996). See Appendix to this chapter for Fulder's taxonomy); Ernst (1996); Lewith, Kenyon and Lewis (1996) and Stone and Matthews (1996). It attempts to combine the strengths of a taxonomy that distinguishes therapies according to the training and legislation needed with the important insights of those who understand the deeply religious and spiritual aspects of complementary and alternative medicine. While some classification systems (like West's) recognize the existence of the paranormal, and others, like Fulder's, find a place for faith healing, the mix of metaphysical, psychic, occult and spiritual practices of alternative medicine needs a much more refined taxonomy. The taxonomy proposed here might be useful in that it clearly distinguishes those practices that are a type of medical system, or are natural methods requiring professional training, from those which are in some way religious or spiritual in that they are metaphysical, psychic or occult or are explicitly religious. A client visiting a homeopath

has the right to expect the homeopath to follow his or her own system of diagnosis or cure. Any deviation will become obvious. For example, the use of pendulums (swinging the pendulum over the client's wrist to diagnose low blood sugar) is not part of modern homeopathic diagnosis, nor is astrology. Yet some homeopaths use these methods (personal experience, 1990). One ought to be seriously concerned if a practitioner has wandered outside his or her area of expertise or is not complying with standards laid down by his or her professional associations. This is an important point as some alternative practitioners tend to offer a syncretistic potpourri of practices from many sources, some which have been validated by long use and are licenced, for example chiropractic manipulation, and some which have not, for example the reading of auras.

The following divides alternative medicine into four broad categories: the professional/medical with metaphysical roots; the metaphysical, psychic and occult (based on McGuire's division); the specifically religious; the natural. In these taxonomies categories can overlap: the professional/medical types of alternative healing listed here are based on metaphysical vitalist ideas (the homeopathic vital force); seemingly mechanical methods like therapeutic touch are imbued with occult ideas; some religious forms of healing claim to be Christian but incorporate belief in the paranormal; some types of psychic healing take the form of Christian prayer; religious groups may use relics and occult groups amulets in essentially the same fashion; many natural methods incorporate magical practices such as the use of dowsing rods or pendulums to diagnose.

The author's taxonomy is as follows:

Professional/medical with metaphysical roots

In this category one could place homeopathy, osteopathy and chiropractic, which, as practiced today, follow a style and ritual similar to that of biomedicine. In fact, American-trained osteopaths are considered to be physicians. Yet homeopathy, osteopathy and chiropractic have decidedly metaphysical origins. While on the surface, they appear to have nothing in common with religion, all three founders of these therapies were deeply influenced by mystical ideas which blended Christian and metaphysical thought. Most notable in homeopathy is the theory of vitalism, which holds that invisible energies are responsible for healing and that it is the healer's job to balance them. The following is a description of some of these forms of alternative medicine.

Homeopathy

When Samuel Hahnemann (1755-1853) founded homeopathy, he believed that the body had a vital force, an innate healing mechanism, which could be stimulated by the administration of infinitesimal doses of a substance similar to, or the same as, that which caused the disease. He believed that his medicine "had unveiled the secret whereby humanity might bring physical events under the action of a 'higher law'". He thought his remedies worked spiritually upon the vital force with which humans are energized (Fuller, 1989, 25). Without vital force, Hahnemann said, the body dies (Hahnemann, 1842/1996, 15). Fuller believes that the first homeopaths were "among the first to align alternative medicine with powerful currents in the period's unchurched religious thought" (Fuller, 25).

Modern homeopaths believe in the vital force but might not discuss their treatment in an

overtly spiritual fashion. A homeopathic consultation consists of an extensive interview in which the client is asked whether she feels better in hot weather or cold; eating spicy food or bland, and other questions related to sleeping patterns or exercise. Then remedies are carefully selected according to homeopathic principles. Following the homeopathic dictum that “like cures like” (the doctrine of similars), remedies mimic the presenting symptoms. For example, a person with swellings might be given *apis*, which is derived from crushed bee stings. Homeopathic remedies are made up from animal, vegetable or mineral sources and shaken (succussed) in a liquid from which *pilules* (pills) are formed. The highest doses contain not a molecule of the original substance. It is this aspect of homeopathy that causes scientists the greatest difficulty. To a scientist, the idea that a medication containing no molecules of the treating agent could have biological activity “is frankly unbelievable” according to Edward H. Chapman, MD, PhD, a clinical instructor at Harvard School of Medicine (Chapman, 1999, 476).

Some scientists have found a way to accommodate the homeopathic belief in the infinitesimal dose and the doctrine of similars to conventional scientific thought.²² For example, Chapman says that isopathy, a conventional approach parallel to homeopathy, uses weaker or smaller doses of a disease-causing agent to create resistance and desensitize the

²²Recent discoveries of the *IE* structure in water may explain the mechanisms of action of homeopathy. These structures are “crystalline-like structures of water molecules generated in response to electrical dipoles surrounding ions or proteins in solution. They have a circular symmetry and are measurable by ultraviolet transmission; they are also visualized by electron microscopy and atomic force microscopy. At ion concentrations below 10^{-7} , these structures become stable and when exposed to shearing forces, break apart into three nanometer fragments but then reaggregate into more stable structures that are capable of self-replication in more dilute solutions, despite the absence of the original polar molecule. The form that these aggregates takes is determined by the electrical field of the original polar solute around which they formed. The shape of these aggregates may contain information that is communicated to highly specific receptor sites on cell surfaces, antibodies, and so on” (Lo SY, 1996; 10 (19): 909-919; 921-930 cited by Chapman in Jonas and Levin, Eds., 1999, 477).

patient. Treatment by similars poses a grave conceptual challenge to modern science but, Chapman says, it may explain the well-known incidence of paradoxical effects people experience when taking conventional medications. For example, the stimulant Ritalin calms those with attention-deficit hyperactivity disorder but agitates those who do not suffer from ADHD. Digitalis can produce the cardiac arrhythmias it is used to control. These effects are well-documented but the mechanism of action is not understood (Chapman, 1999, 474).

Osteopathy

Andrew Taylor Still (1828-1917), the founder of osteopathy, had visions, believed in clairvoyance and had a strong interest in spiritualism (Gevitz, 1988, 161). He may well have been influenced by Andrew Jackson Davis (1826-1910) who tried to combine spiritualism with magnetic healing or mesmerism. Still accepted the doctrine of harmony and adopted manipulation as a method of restoring balance without the use of drugs which he believed were unnecessary. According to Fuller, Still thought that physiology was the “conduit through which a higher order of life might enter... .” The idea was that the body cured itself when the relationship between the different bodily structures is normal. Fuller states that “physiology was for Still what states of consciousness would be for holistic healers in the 1970's and 1980's” (Fuller, 1989, 85, 25). Some people came to ask if Still was an agent of the devil and he was read out of the Methodist Church (Gevitz, 1988, 163).

Osteopaths restore function by manipulating parts of the body.

Chiropractic

Daniel David Palmer (1845-1913) the founder of chiropractic, was drawn to spiritualism and was influenced by the mesmeric healer Paul Carter who claimed that he could transfer his curative magnetic powers to a sick patient by rubbing and slapping the patient's body.

Magnetic healing offered Palmer a way to develop (or to appear to have developed) intuitive and clairvoyant gifts. Palmer believed that “vital energy flowing from the brain” is sometimes blocked when the vertebrae are out of alignment, causing disease. Manual pressure restores the flow of vital force. Ultimately, Fuller says, Palmer believed that chiropractic acknowledged that the body expresses a divine reality. The vital force, which he called “Innate”, he believed to be part of “Universal Intelligence”. Fuller sees Palmer as fusing spiritualist, mesmerist and vitalist ideas. He saw “in his metaphysical system an all-embracing key to understanding humanity’s relationship to God” (Fuller, 1989, 68-71).

Chiropractors manipulate and make adjustments to the spine to relieve pain and restore function.

Most modern practitioners of these three types of alternative medicine have distanced themselves from their metaphysical roots. This is particularly true of chiropractic and osteopathy. Fulder says that some “now find themselves burdened by some outmoded concepts ...such as the innate intelligence in chiropractic...or [the belief in inherited] tubercular miasms of homeopathy” (Fulder, 1996, 20).

Metaphysical, psychic and occult

In the twentieth century, the most well known metaphysical, psychic or occult healing methods include crystal healing, Therapeutic Touch, Reiki, channeling and divination. I have divided psychic or occult methods from metaphysical methods according to whether or not the source of power is believed to be transcendent or immanent. Meredith McGuire claims that the major distinguishing factor between the two types of healing is each group’s concept of the source of healing power. Metaphysical groups believe an immanent power is within the reach of each believer. Psychic and occult healing groups are similar to Christian

healing groups in their belief in a transcendent rather than an immanent healing power. However, psychic/occult healing groups believe that any psychically developed person may tap into healing power and they do not believe that healing energy is necessarily sacred. Anyone can be a mediator. When psychic/occult groups believe that the individual has power within herself they are similar to metaphysical groups (McGuire, 1988, 79, 130, 223, 130, 150, 55).

Healing rituals also differ according to whether they use metaphysical healing methods or psychic healing methods. Metaphysical groups tend to heal by affirmation rather than supplication, saying, for example "the healing has occurred." Unintentional words and thoughts are viewed as powerful. Psychic and occult healing groups tend to use decrees, ordering the illness to go away, in rituals of performative utterance to purify the body and transmute disease. Some psychic healers, like Christian healers, are seen as mediators who are specially anointed or selected for this task but not every healer needs to have this sacred power. Metaphysical groups use few or no "sacramental" objects in their rituals. Psychic and occult healing groups are similar to Christian healing groups in their use of sacred objects (McGuire, 1988, 216, 218, 217, 233, 237, 221, 155-156, 221).

Psychic healing covers all practices in which some sort of parapsychological ability is used to heal. The practitioner believes that nonphysical energies can be transmitted across distances to heal (Fuller, 1989, 103). Larry Dossey, MD describes many studies on distance healing (see Dossey, 1999). He believes that prayer is a form of energy and refers to double-blind trials in which one set of patients knows that a healer is focusing on them and another set does not. In later studies, patients did not know they were in a study. Eisenberg's researchers, who included prayer in the list of alternative techniques, decided not to include prayer in the analysis. Occult healing is that which relies on secret knowledge

or on concealed powers sometimes presumed to reside in objects.

Following is a description of some metaphysical, psychic or occult forms of healing:

Reflexology, Iridology -- metaphysical

Reflexology and iridology are both systems which claim to be scientifically based but have metaphysical origins. Reflexology is based on a system of correspondences in which every organ of the body is believed to be replicated on the soles of the feet. It is used to treat problems such as migraine headaches, poor circulation or backache (Fulder, 1996, 224). The reflexologist applies pressure to a specific area so as to move energy along the meridiens or channels so that toxins are released and the body healed. Iridology is a diagnostic system that holds that the organs of the body are reflected in the iris. Iridology was developed by the Hungarian Ignatz von Peczely and adapted by Bernard Jensen, an American chiropractor in the 1950's. In this system, every organ, part and function of the body is assigned to a specific location on one or both irises. The degree of light taken into the iris indicates the presence or absence of health and the iridologist identifies organs he or she believes to be diseased by viewing the eye through a special camera (Guinness and Rutherford, Eds., 1993, 168-175, 82-85).

Therapeutic Touch -- metaphysical

Therapeutic Touch is classified as a physical method and is taught in some nursing schools (several provincial Canadian nurses associations recognize it as a legitimate nursing practice). Founded by nurse Dolores Krieger in the 1970's, who studied under the Canadian healer Oskar Estabany (who collaborated with Bernard Grad in the study of wound healing in mice (Grad, Cadoret and Paul, 1961; Grad, 1965 and see Fugh-Berman, MD, 1997, 156 and Dossey 1999) it is based on the belief that each human body projects a field of energy

which, when blocked, causes disease. Practitioners claim that they can detect and correct blockage (Guinness & Rutherford, Eds., 1993, 96-97). It is a metaphysical technique in that practitioners believe the healing power resides in the healer and is not transcendent. In Therapeutic Touch, the practitioner moves her hands on or over areas of the client's body to release "blocked" energy fields.

Reiki -- metaphysical with occult elements

Reiki is a healing method developed in the mid-nineteenth century by Dr. Mikao Usui, a Japanese theologian who claimed to discover the principles in which Reiki is grounded in ancient Sanskrit manuscripts. Reiki practitioners believe in Universal Life Energy which, when channeled, can heal. Healers are trained by a Reiki Master and receive "attunements". The Master traces ancient symbols of energy on the trainee's head and on the chakras (an Ayurvedic concept that refers to energy channels in the body. The heart chakra, for example, is connected to emotions) (Guinness and Rutherford, Eds., 1993, 99).

Reiki is presumed to work not through the skill of the practitioner or the way she places her hands but in the way the practitioner transfers energy. Energy is said to flow between practitioner and client in a continual and reciprocal flow. Nurse Myriam Lavoie is a Reiki practitioner as well as a trained Therapeutic Touch therapist. She says that Reiki energy goes where it is most needed. It is released on an unconscious level. She describes Reiki as a spiritual practice and journey that can be used with the dying to manage pain, relieve emotional distress and enhance the experience of oneness without separation. However, she warns, it can trigger memories and cause stress (Myriam Lavoie, presentation at conference, *Complementary and Alternative Medicine (CAM) and end-of-life care for seniors*, Toronto, Ont., February 24, 2000).

Creative visualization -- metaphysical, psychic, occult

This is a method that relies on the power of imagination to transform reality. Although it is a scientific method that harnesses the power of the mind and imagination to influence the body to become well (see Achterberg and Lawlis, 1984), it can also be an occult practice if the person engaged in such an imaginative act, usually in a state of deep relaxation, truly believes or is told to believe that the imagined reality is the true one. The method could be seen as a form of magic in which one controls the universe with one's thoughts.

While creative visualization is promoted as a way to fight cancer or stress, some believe it is psychologically and spiritually dangerous. Osborn sees in this practice the danger of indoctrination as the leader of a guided-fantasy/creative visualization session (in a classroom, therapy or self-help group) can powerfully influence the participants with his or her own beliefs and thoughts. This can be a form of indoctrination in which the individual's critical faculties are bypassed. Osborn, like some other Christian writers, believes that creative visualization can encourage belief in one's own power rather than promote dependence on the power of God. It can even, Osborn says, lead to demonic influence or possession (Osborn, 1992, 58-60; 76-78). A type of visualization is, however, also a common practice of Christian prayer -- the Rosary and the Exercises of St. Ignatius are both methods based on the idea of spiritual transformation through meditating on scenes from the life of Christ (see Osborn, 77).

Divination -- metaphysical, occult

Divination relies on a form of extra-sensory perception and could be classified as metaphysical. It is also occult, its devotees believing in the hidden powers of runes, tarot cards, the I Ching, pendulums and divining rods for diagnostic purposes. Some believe that the skill, like healing skills in general, can be learned by anyone; others believe this is a

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special gift either acquired through inheritance (a belief popular in England from the seventeenth to nineteenth centuries held that the seventh son or daughter of a seventh son had special healing powers, Thomas, 1971, 237-239) or a gift of God (see Fulder, 1996, 177). The use of pendulums for diagnosis is also called dowsing or radiesthesia (see Osborn, 1992, 19; Fulder, 1996, chapter 20). Divination can be used to diagnose or predict illness.

Crystal healing -- occult

Adherents of crystal healing believe that crystals can channel the energies of the universe, harmonizing the body with divine harmony. In the West, Baron Charles Von Reichenbach (1840's) refined Mesmer's theory of animal magnetism (see chapter five), reconceptualizing it as "Odic Force". He believed crystals, like Mesmer's magnets, activated this force (Fuller, 1989, 111-112). This is an occult rather than a metaphysical practice in that it taps into a transcendent healing source with the use of an object. A modern crystal healer might place crystals believed to have healing power on energy points in the body, or distribute them around a room to attract or dispel energy in space.

Spiritualism -- occult

Spiritualism, in which the dead are presumably contacted through seances, was enormously popular in the nineteenth century. As a movement, it has links to mesmerism and Swedenborgianism. As noted above, Andrew Jackson Davis attempted to link spiritualism with magnetic healing. Davis began by travelling about the country, placing himself into a mesmeric trance during which he would perform such feats as reading books blindfolded. Davis came to believe that the powerful truths he experienced while in a trance state were communicated to him by the spirits of the dead, particularly the spirit of Emanuel Swedenborg. Davis' main work is *The Harmonial Philosophy* in which he claimed, with the

help of spirit guides, to join mesmerism and Swedenborgianism. Davis became a “trance channeler” who healed (Fuller, 1989, 56-57). Early spiritualists used the same methods as the mesmerists. They believed that illness resulted from blocked vital fluid and used their hands to restore its flow, much as modern practitioners of Therapeutic Touch do. As noted before, Palmer, the founder of chiropractic and Still, founder of osteopathy, developed their theories and methods from mesmerism and spiritualism (Fuller, 57). Spiritualism is related to modern parapsychological techniques such as channeling and psychic healing.

Channeling -- psychic, occult

Channeling is a twentieth and twenty-first century form of spiritualism in which disincarnate beings or extra-terrestrials are invoked. It can be used as a healing method. Channeling is a psychic/occult type of practice in that a deceased or otherwise transcendent being is appealed to. When in a trance, the channeler may be the conduit for angels, ascended masters, ancient goddesses, animals like dolphins (Hanegraaff, 1998, 23- 24). Objects may also used -- perhaps a relic of a deceased person such as a garment to draw the spirits closer. Lawrence Osborn notes that the term “channeling” replaced spiritualism and mediumship because of mediumship’s negative connotations (many were found to be fraudulent) (Osborn, 1992, 54-55) but channeling appears to go far beyond spiritualism in the type of spirits it invokes. Popular books, such as *A Course in Miracles* by Helen Schucman (see Hanegraaff, 30, 37-38) were purportedly written by disincarnate spirits and channeled through their authors (Osborn, 55).

Psychic healing

Psychic healers often feel that they have been religiously called. Their power is a gift. Many claim that they are called to this vocation by spirit guides and/or channel spirit guides when they heal. Lawrence LeShan, who is a transpersonal psychologist, combines theories about

post-Einsteinian physics and paranormal beliefs to claim the existence of a “Clairvoyant Reality” that transcends the world of cause and effect. LeShan claims that psychic healing is proof of the existence of the Clairvoyant Reality. He believes that in Type 1 healing, a healer merges with the patient by entering an altered state of consciousness. This is done through a technique such as prayer or drugs which are the vehicles in which the healer is transported into the Clairvoyant Reality. The patient is enclosed in a “psychic field” and is able to heal himself. In LeShan’s Type 2 healing, the healer transmits energy in a manner similar to that of nineteenth-century mesmerists who claimed that they transferred animal magnetism to clients. LeShan claims that psychic healing reveals the truth of all religions — that “God is Love”(Le Shan, 1974 in Fuller, 1989, 108; Fuller, 1989, 106-108).

Specifically Religious Forms of Healing

Faith healing and spiritual healing

Fulder distinguishes faith healing from psychic or spiritual healing. He believes that in faith healing, the physical and psychic powers of the patient interact to release capacities of self-healing under the power of a healer or under hypnosis. In spiritual healing, he says, a type of energy, “as yet unknown” is transmitted from healer to patient in a paranormal fashion (Fulder, 1996, 177).

Faith healing may take place at revival meetings or Catholic Charismatic Renewal rallies, with the laying-on-of hands; in denominational groups like Christian Science or Pentecostal churches; individually or in small groups in which friends offer healing to one another without the mediation of a healer. Those that may pose the most ethical difficulties involve groups with powerful leaders who sometimes exercise a seductive attraction on those who seek healing. A person seeking healing may then become a devotee of a religious group.

Distance healing is a type of spiritual or psychic healing if one uses Fulder's definition. Some medical researchers have conducted double-blind controlled studies of prayer in which hospitalized patients were randomized so that some received intensive prayer from a group of pre-selected pray-ers and others did not. In an early (1988) study, by Randolph Byrd, MD, the patients knew they might be in a group that was prayed for. A later study by Harris and his colleagues changed the Byrd study by making sure that neither the patients nor the medical staff knew of the study's existence (to avoid what is called "expectation efficacy"). Informed consent was not sought and patients were not pre-screened (Harris et al., 1999, October 25, 2273-2278).²³ One of the questions these studies try to answer is whether prayer functions independently of the intentions or even the knowledge of the recipient. This would be a typical example of psychic or spiritual healing. However, the person calling upon God or Jesus to heal would be unlikely to call this exercise psychic healing.

Religious denominations focused on healing

Christian Science is the most well known of two Christian denominations in which healing takes a central role. The other is Seventh Day Adventism. Both were founded in the United States in the nineteenth century. Christian Scientists believe that illness is an illusion based on errors of the mind. Its founder, Mary Baker Eddy, taught that sickness has no ontological reality. Christian Science healers ask God to remove the error of the mind so that the body will become the perfect creation God intended (Christian Science Publishing Society, 1966, 240; Battin, 1990, 79). Their work is often reimbursed by insurance companies. This removes Christian Science healing from the realm of the purely religious

²³Although the Canadian Tri-Council guidelines on research ethics (and many other research codes of ethics) make provision for suspending the requirement for informed consent, one wonders how militant atheists might feel if they knew they were part of such an experiment.

and into the quasi-medical. Because, according to McGuire, the church has re-defined healing as teaching or caretaking (Christian science nursing homes exist for non-medical and non-pharmaceutical care), the church has managed to avoid conflicts with the medical establishment (McGuire, 1988, 80).

Seventh Day Adventism, founded by Ellen Gould White, was based on health reforms promoted by Sylvester Graham (1794-1851). Graham was opposed to alcohol, sexual excess, and refined flour which, he believed, was overstimulating. The unrefined wheat flour crackers, made according to Graham's specifications, are on most supermarket shelves today. Heavily influenced by Graham's asceticism, White believed that God had vouchsafed to her laws of hygiene as important as the Ten Commandments. All who waited for the Second Coming of Christ were to prepare their bodies by eschewing all that would pollute. John Harvey Kellogg was one of White's disciples and developed the Western Health Reform Institute, founded by White in Battle Creek, Michigan, into a health resort. It was there that Kellogg and C.W. Post created the corn flakes, bran and other dry cereals for which they are famous (Fuller, 1989, 30-33). Still dedicated to health through clean living, Seventh Day Adventists are now well-known for their stop-smoking programs.

Pilgrimages, shrines, amulets

Throughout history, certain places have been designated as sacred sources of healing to which people make pilgrimages. Lourdes is the most famous in the Christian world. Jerome D. Frank and Julia B. Frank refer to the fact that those who make pilgrimages to shrines often share the same world view. The pilgrimage can place people in a liminal state in which they are more open to the power of suggestion. This is a somewhat reductionist approach, however. Frank and Frank admit that some people (and presumably some places) have a gift of healing that cannot be explained (Frank and Frank, 1991, 103-105, 111).

Amulets are objects worn by people who hope that they will protect or heal. They may be religious relics or symbols, a rabbit's foot, sacred texts engraved on precious metals. A modern ritual, described by Michael D'Antonio (*Heaven on Earth*, 1992), combines several of the methods mentioned here. Pursel, who channels a spirit called Lazaris, enters a room of people in silence. No one is to speak to him or touch him. Each devotee goes to the stage upon which Lazaris/Pursel sits. He strokes their throats or abdomens to heal their energy then presses a crystal into the hand of each supplicant who then return to the seats. Once seated, some held up their crystals, gazing at them reverently. Here crystals, which (see above) are considered to be particularly powerful energy channels, are given to worshippers by a shaman-like character who is said to channel the spirit of a powerful healer (D'Antonio, 1992, 151-152).

Natural

Under this heading one could include naturopathy, a system of healing founded in 1900 by Dr Benedict Lust; herbal medicine; Bach flower remedies and, perhaps, folk healing.

Naturopathy

Naturopathy is the art and science of promoting health and preventing and curing disease by natural methods. It is based on the belief that the body heals itself with the help of botanical medicine, homeopathy and other alternative methods. Naturopaths strongly believe in the *vis medicatrix naturae*, the healing power of nature. Naturopathy is a successor to the ideas of Graham, Kellogg and Post, inventors of healthful cereal products (still to be found on many breakfast tables) and nineteenth century healthy living enthusiasts. Naturopathy is a distinctly American healthcare system that unites various types of alternative medicine: herbalism, homeopathy, acupuncture, certain types of manipulative therapies (Guinness and

Rutherford, Eds., 1993, 76.) with conventional medical diagnostic systems. In Canada, the central training school is in Toronto and students are trained similarly to conventional medical doctors. A Bachelor of Science with pre-medical studies is mandatory for all applicants. Naturopaths see themselves as the general practitioners of complementary and alternative medicine.

Herbal medicine

Herbal medicine is an ancient form of medicine. In the past it included a belief in the doctrine of signatures, an ancient notion made popular by Paracelsus in the sixteenth century. In this system, the physical appearance of herbs corresponds to the organs they are intended to heal. It was believed that God “signed” plants and flowers so that people would know what they were to be used for. Hence Chinese lantern, with a calyx shaped like a bladder, is meant to cure urinary problems (Dwyer and Rattray, Eds., 1986, 58). Herbalists also believed in propitious times, based on astrology, for picking herbs, and some still do. This is, to some extent, based on good scientific gardening principles. For example, medicinal herbs are best harvested in early morning (Herbs for Health, 1999, Sept/Oct 16). But practices such as selecting astrologically propitious days to pick herbs have no foundation in modern science. Modern herbalists have mainly distanced themselves from their “magical” predecessors but some retain these beliefs. Even today some choose healing plants according to their morphology, believing that the shape of the plant and the way it grows give us insight into the nature of the flower. Hence sunflower essence (used in Bach flower remedies, see below) is supposed to synthesize personality and thought because it is a composite flower containing many smaller florets and is built on the principle of synthesis and expression (Katz, 1994 in Morrison, 1995, 126). The ancient doctrine of signatures thus survives in a modern healing system.

Herbal medicine has attracted the interest of pharmaceutical companies and government health protection agencies. At a November 1998 conference on complementary medicine, William S. Reynolds, President of Reynolds and Associates, gave a lecture on *How to Deal with Standardization of Product*. He discussed the possibilities offered by more scientific research into the action of such herbs as echinacea and St. John's Wort. Echinacea angustifolia was used by native Amerindians as a cure for fever, among other things; St. John's Wort is a plant that has been used for centuries to repel demons, heal wounds, cure tuberculosis and other respiratory ailments. It is now used as an antidepressant to rival (in mild cases of depression) Prozac and other related products. In particular, scientists want to discover what parts of the plants are most effective and to resolve the difficulty of calibrating dosage so that each bottle will contain an identical amount of the active ingredient. This is a challenge as identical plants in two adjoining fields may yield remedies of varying potency (Reynolds, Conference: *Complementary Medicine in the Mainstream*, Toronto, Ont., Nov 23-24, 1998).

Some herbalists question the modern emphasis on standardization, claiming that this does not necessarily make a herb more effective and that it is an approach antithetical to the personalized, holistic approach of traditional herbalism (Tierra, July/Aug, 1999, 6-9). Those who practice in this way, they say, are using the conventions of biomedicine -- one drug targeted on one disease -- to apply a holistic product.

Bach flower remedies

Closely related to herbal medicine (as well as to homeopathy as extracts of flowers are diluted according to homeopathic principles (Fulder, 1996, xix) is the Bach Flower Remedy system -- a method of healing founded by British physician Dr. Edward Bach (1886-1936). Bach developed a method which identified thirty-eight healing plants corresponding to

negative human emotions which he believed caused illness. Plants are distilled into liquid remedies, the most famous of which is the Rescue Remedy, recommended for treating the emotional effects of sudden shock. Although listed as a natural healing system, the ideas inherent in the Bach Flower remedies are metaphysical. Like homeopathic remedies, they are presumed to activate subtle energies in the body. Flowers are selected for their specific healing properties and their essences are obtained by floating them in water in morning sunlight. The “energy resonance” of the flowers is, according to proponents of this system, absorbed by the molecules of the water which, when drunk, vibrate throughout the body of the individual sufferer, harmonizing his or her energies (Morrison, 1995, 80). One could also view this system as occult in that an object -- the flower -- is used to release the energy.

Folk medicine

Every culture has a tradition of folk medicine. Herbal medicine is a significant part of folk practice but one could also include other lay techniques when practiced in indigenous cultures. Folk medicine may cross categories into pure religious healing. One example is the powwow tradition of Pennsylvania, brought by settlers from German-speaking parts of central Europe. The English-speaking colonists gave this ritual the Algonquin word; the German term is *Brauche* or *Braucherei*. The tradition is religious, using whispered prayers and scripture verses, often accompanied by the laying on of hands. The tradition makes much use of charm books compiled for healing animals and people, catching thieves and preventing the harm of witchcraft. The ritual is found mainly among Protestants but, according to Hufford, it has Catholic features. He accounts for this by saying that the Protestant Reformation drove religious healing underground but that “such suppression was never completely successful because of the consistent folk tendency to retain a sacramental world view despite” Protestantism’s “radically transcendent stance.” Hufford points out that though it is a tradition of religious healing, powwow is strongly connected

with natural healing and coexists with a herbalist tradition (Hufford, 1988, 231-233).

Conclusion

Some of the methods described above, which is by no means an exhaustive survey of all forms of alternative medicine, could, potentially, become complementary, and used as an adjunct to conventional medicine. This may present particular problems. A major difficulty is that conventional appropriation of alternative medicine may rob alternative medicine of its numinosity. It might also deprive patients of one of the most compelling reasons to use alternative medicine -- to find a healer/doctor with time and a sympathetic ear. The next chapter will look at who uses alternative medicine and the reasons they do so.

Chapter Three

Appendix

Fulder classifies therapies into the following categories:[note:general categories are in bold-face type; main therapeutic specialties in bold-face italic type; subspecialties in italics]:

(1)Medical systems which include ***complementary medicine*** (separate from scientific medicine and less interventionist according to him); ***conventional medicine***; ***far Eastern medicine*** (Chinese, Japanese, etc); ***folk medicine*** (unwritten and unsystematic among lay people); ***holistic medicine*** (which combines conventional and complementary medicine, often within the setting of a general practice); ***Indian medicine***; ***traditional medicine*** (indigenous diagnostic and therapeutic practices).

(2)Therapies in complementary medicine. Complementary therapies include ***acupuncture*** (and ***acupressure***); ***ear acupuncture*** and ***auricular therapy***; ***moxibustion***; ***anthroposophical medicine*** (Rudolf Steiner's harmonial system, including ***eurythmy***, an anthroposophical method of movement and dance (Fulder also lists ***speech and art therapy*** under this category); ***aromatherapy***; ***breathing therapies***.

Diagnostic therapies which include ***iridology***; ***auric diagnosis*** (psychic diagnosis by color analysis of auras which are emanations of energy surrounding the body); ***Kirlian photography***.

Electrical therapies which include ***magnetic field therapy***, ***diathermy*** (using equipment to send pulses of electromagnetic energy into the tissues); ***ion generators***.

Healing, including *faith, spiritual, magnetic, mental healing* and *laying on of hands*; *absent healing*; *prayer healing*; *spirit healing* (including *exorcism*); *auric healing* (healing directed towards the “subtle” or etheric aura of the body).

Homeopathy including *biochemic remedies* (small amounts of salts used according to homeopathic principles); *Bach flower remedies*.²⁴

Hydrotherapy including *balneology* and *spas*.

Manipulative therapies including *chiropractic, osteopathy, cranial osteopathy, bonesetting, massage, kinesiology, postural integration, reflexology* (massage of zones of the feet); *polarity therapy*; *rolfing*.

Naturopathy including *nature cure, hygienic systems*.

Nutritional therapy and clinical ecology including *dietetics, monodiets* (ie just grape juice); *fasting, vegetarianism; veganism* (excludes all bird, animal, fish products); *macrobiotics*.

Postural therapies including the *Alexander Technique, Feldenkrais Technique*.

Radionics (use of pendulum and instruments as a focus of psychic power to diagnose and select treatments) including *medical dowsing, radiesthesia*.

²⁴Homeopathy may also be described as a complete system of medicine, save in cases of accident or trauma.

Mind-body therapies including *Autogenic Training* (implanting positive suggestions by self-instruction), *hypnotherapy*, *bioenergetics*, *biofeedback*, *relaxation techniques*, *meditation* and *visualization*.

Remedies, including *home and natural remedies*, *herbs*, *health products*, *mineral remedies*, *organic remedies* (use of tissues, extracts); *herbalism* as a therapeutic system based exclusively on the curative power of herbs.

Sense therapies including *colour therapy* and *sound therapy* (Fulder, 1996, xv-xxiii).

Strengths: This taxonomy is extremely detailed and comprehensive and includes faith and spiritual healing. Fulder also makes the important distinction between faith healing and psychic or spiritual healing (Fulder 1996, 177).

Weaknesses: Alternative paranormal techniques could have had a category of its own.

Chapter Four

Who Uses Complementary and Alternative Medicine? Why and How Do They Use It? Who Practices It?

Who Uses Complementary and Alternative Medicine?

Many hypotheses exist to explain why people use complementary and alternative medicine, partly because these practices are so diverse. One cannot easily define a typical user of alternative medicine as some conventionally-minded people might use massage therapy while the more adventurous might try homeopathy instead of conventional medicine for a mild ailment. What all have in common is a consumer approach to medical care. Alternative medicine is a marketable commodity, just as conventional medicine is in countries like the United States. When people feel confident that conventional medicine will cure them, they may ignore the claims of alternatives. But if they suffer from a protracted, chronic disease, such as arthritis, for which they can find only partial cures and minimal symptom relief, they may well search the marketplace for something that works. Those living with cancer or AIDS might find alternatives appealing because medical science cannot offer cures.

Many studies have been conducted to assess the extent to which specific populations use alternative medicine. The results are often used to bolster claims that alternative medicine is gaining in popularity at the expense of more conventional healing methods. To assess these studies correctly, as noted in the last chapter, one should look at what the authors classify as alternative medicine. A review of these studies indicates that some include the practices of allied health professionals such as midwives (Lori B. Andrews, 1996) and such mainstream activities as relaxation techniques, exercise and prayer (Eisenberg, et al, 1993). Nonetheless, Eisenberg's most recent study indicates a dramatic increase in the use of all forms of

alternative and not-so-alternative medicine (Eisenberg, 1998, Nov 11, 1572) and this is supported by other contemporary surveys. Who are these alternative consumers?

Innumerable commentators (for example McGuire, 1988, Eisenberg, 1993) have observed that people who use alternative medicine are usually educated and members of the middle class. The 1990 Eisenberg study indicates that of the 61 million Americans who used what the authors termed an “unconventional” therapy, a large number had at least some college education and could be described as middle class (Eisenberg, 1993, 246, 248). The study was restricted to English speakers. Eisenberg’s original and follow-up study both found that people with some college education, and those earning more than \$50,000 a year, used alternative medicine more frequently (Eisenberg, 1998, 1571). John Astin of the Stanford Center for Research in Disease Prevention conducted a survey in 1997 involving written responses which yielded similar results. The poor and uneducated were slightly underrepresented which is what one might expect of a written survey (Astin, 1998, 1550-1553).

Adrian Furnham says that all studies show that those who use alternative or unconventional therapies are better paid and better educated (Sharma, 1992; Fulder and Monroe, 1985 in Furnham 1996, 73). A study conducted by the *Office des professions* of Québec also revealed that, approximately ten years ago, the typical consumer of alternative medicine in Québec was a francophone woman between the ages of 35 to 44 with a community college or university education and earning more than \$45,000 a year (août 1991, 9. 3. 1). The very young and very old tend not to be found in alternative medical practices (Fulder, 1996, 35). It would seem that alternative medicine, thought by some to exist on the fringes of health care, draws many of its adherents from the middle classes, or at least people in the mainstream of society. Many if not most of those who seek out alternative cures are neither

the scientifically untutored nor the desperate in search of a cure for incurable illness.

As mentioned in the section on terminology, people are consumers of both conventional and alternative medicine, often using biomedicine for diagnosis and alternative forms for cure. Furnham says there is no “prototype” patient and patients rarely choose one form of medicine over another exclusively (Furnham, 1996, 73-74 and 80). Meredith McGuire says that some turn to biomedicine’s diagnostic superiority to reassure themselves that their symptoms do not indicate life-threatening illness (McGuire, 1998, 193-195, 146). They may then turn to alternative medicine for cure or the alleviation of symptoms or may combine alternative and conventional medicine. Some physicians, likewise, combine alternative and conventional practice. Fulder believes that if people are using alternative therapies as complementary to rather than a substitute for conventional medical care, then it shows they are taking control of their own healing (Fulder, 1996, 43). He overstates his case, however, when he says that this growing trend reveals that “the giant of modern medicine has indeed been caught napping” (Fulder, 33) and “the public has turned to complementary medicine as refugees from the inadequacies of conventional medicine” (Fulder, 13). A number of studies, to be discussed shortly, refute this. Consumers of complementary and alternative medicine also value conventional medicine. The two surveys by Eisenberg revealed that a large number of people who went to an alternative practitioner for a health problem also went to a physician in the 12 months prior to the interview (96% in 1990 and 1997) (Eisenberg, 1998, Nov 11, 1572-1573).²⁵

²⁵Eisenberg’s second study, after eliminating ineligible subjects, managed to get 41.3% of their interviewees to finish the interview on the first request. However, the researchers then tried to encourage a random subsample of 1066 people who had initially refused by offering them an increased stipend of \$50.00. All other interviewees had been offered \$20.00. No money was given in the 1990 survey (Eisenberg, 1998, Nov 11, 1570). One might ask if this did not skew the study in some way as even small amounts of money can be a coercive inducement.

The problem with the surveys cited lies in their focus on more privileged members of society. Surveys of English-speakers who are available by phone (Eisenberg) exclude many ethnic communities. Surveys like Astin's, which are directed towards those who actually enjoy filling out forms and have a good command of English, will necessarily exclude others who may use alternative or folk medicine but are not "eligible" to let researchers know about it.

As noted before, survey results will depend on what is defined as alternative medicine. Furthermore, specific groups, such as people with HIV, use complementary and alternative medicine more extensively than the general population (York University Health Services, 1999, 7).

While Americans might be said to use alternative medicine because it may be cheaper than conventional medicine, Canadians do not have the same financial incentive as conventional medical care is free in Canada. Furthermore, people who go to alternative practitioners do not lack access to conventional treatment. Many live in urban centres where they can easily find specialists in conventional medicine. Yet alternative practitioners are most numerous in precisely those areas with the greatest number of conventional doctors and hospitals (see Fulder, 1996, 34, Sharma, 1992, 13). One is less likely to find an alternative practitioner on the remote Newfoundland coast than in Toronto, Vancouver or Montreal. Many people, cancer patients included, visit homeopaths, acupuncturists, specialists in Therapeutic Touch, herbalists, naturopaths and may pay up to \$100.00 for the visit alone and perhaps another \$100.00 on various remedies. Obviously cost is not an issue for those who can afford it. But, if alternative medicine is helpful, then the poor are deprived of access, a topic to be discussed in part four, chapter eleven.

One must ask, when looking at the vast field of alternative medicine, whether interest in *specific modalities* has increased in recent years. Taylor points out that different therapies are popular at different points in time. Some may be related to developments, or lack of development, in conventional medicine. For example, nutritional therapies were enormously popular among people with HIV until new and better drugs were developed. In a similar vein, one should note that homeopathy was developed at a time (eighteenth century) that conventional treatment was draconian. However, Taylor also points out that, in the United States, religious healing ministries were most popular during the 1950's, an era when people had confidence in medicine (Taylor, 1984, 204). The popularity of a therapy, therefore, offers only a partial answer to the question of why CAMs in general are so popular. Many believe that dissatisfaction with the doctor-patient relationship or with modern technological medicine are major factors but, as will be explained below, that does not tell the whole story.

In asking why people turn to alternative medicine, and then asking why they turn to this form or that, one might suggest that people who are interested in pain or symptom control and not philosophy might turn to those practitioners most closely allied to medicine: chiropractors and osteopaths who have distanced themselves from their metaphysical origins, homeopaths, who function as and sometimes are, medical doctors, naturopaths who have graduated from a four-year post Bachelor of Science training program with an education similar to that of a general practitioner. Those interested in the spiritual aspects of alternative medicine might turn to Therapeutic Touch (though this may be practiced in the conventional setting of a hospital) but are more likely to join the type of healing groups described by Meredith McGuire or go to a practitioner of visualization therapy or a channeler.

Why and How Do People Use Complementary and Alternative Medicine?

Adrian Furnham says that we do not ask people why they go to conventional doctors. To ask why they would resort to alternative medicine implies either that we think one would not use alternative medicine for ill-health or we believe it is unsafe (Furnham, 1996,71).

Multiple factors probably lie behind people's choice of alternative medicine. This chapter will look at the many reasons put forth by physicians, sociologists, anthropologists and scholars of religion to answer the question "why do people use alternative medicine?" The topic is particularly intriguing to those in the conventional field, who have, until recently, felt secure in the dominance of biomedicine. As noted before, only recently have respected medical journals such as the *Journal of the American Medical Association*; *The Annals of Internal Medicine*; *The Archives of Internal Medicine*; *The Canadian Medical Association Journal* and *The New England Journal of Medicine* given attention to the field.

It is important to bear in mind that, as Ursula Sharma says, one can put forward many theories to answer the question "why do people use non-orthodox medicine?" but the answer can be simple: sick people want to be cured. The implicit message in the question "why do people use alternatives" is why, "when they could use the services of an orthodox doctor for nothing [in Canada and the U.K.]" (Sharma, 1992, 24). Yet not every orthodox specialty is available in a state-administered health-care system or reimbursed by private insurance. When analyzing British and American studies, one should remember that British clients of the National Health Service may not have easy access to medical specialists and that American patients might be insufficiently insured for certain biomedical specialties.

John Astin claims that "there is no clear or comprehensive theoretical model to account for

the increasing use of alternative health care” (Astin, 1998, May 20, 1548). His study, briefly discussed in the introduction to this chapter, was conducted by mail and reached 1035 Americans. Astin hoped to test three theories: 1. that people turn to alternative medicine because conventional treatment did not work for them, had negative side effects, was delivered coldly or was too expensive; 2. that people see alternative medicine as “less authoritarian and more empowering” offering greater control, and 3. that patients see alternative therapies as consistent with their spiritual or philosophical beliefs and values (Astin, 1548). As well as questions designed to validate his hypothesis, Astin asked the study participants whether they experienced health problems. This is an important question as the healthy often approach illness in a theoretical way. Those who are sick have a more pragmatic approach to pain relief and the cure of illness.

Astin’s survey response rate was 69%. It revealed that those who used alternative medicine were better educated (as noted before, the survey method used tends to attract the educated) but had poorer health than the average American. Contrary to the study authors’ hypothesis, those responding to the survey did not turn to alternative medicine because of poor experiences with conventional medicine. In fact, of the 54% who said they were “highly satisfied” with their conventional practitioners, 39% used alternative medicine. Only 4.4% relied almost exclusively on alternative medicine (Astin, 1998, May 20, 1550). The study’s central finding was that alternative medicine users were “no more dissatisfied with or distrustful of conventional care than nonusers are” although Astin points out that some results suggest that those greatly committed to alternative health care are probably more dissatisfied with orthodox medicine than they are committed to alternative medicine on principle (Astin, 1552). The second hypothesis, that people turned to alternative medicine to achieve greater autonomy, also turned out not to be a significant determinant of who uses alternative medicine. What Astin’s researchers did discover was that those who believed

strongly in the interrelation of the health of body, mind and spirit were the most likely to use alternative medicine (46%). Only 33% who did not hold such a philosophy used alternative medicine. Astin believes that this use may reflect the growing perception that spirituality is important to health (Astin, 1550-1552). The people in this study who responded “yes” to the statement: “I’ve had a transformational experience that causes me to see the world differently than before” were more likely to use alternative medicine, as were those classified as “cultural creatives” (interested in environmentalism, feminism, holism) (Astin, 1551). He concludes that people who use alternative medicine do so because it is consistent with their life philosophy (Astin, 1548).

Other researchers have also suggested that alternative medicine’s growth is a result of many factors: legal barriers to alternative practice have disappeared within the past 35 years (Taylor, 1984, 194); biomedicine requires doctors to distance themselves from patients so as to clearly focus on the disease (Kane et al. 1974, Salmon and Berliner, 1980, 198 in Taylor, 196); Western cultural attitudes have changed leading to a turning from science towards the occult (Avina and Schneiderman, 1978, 369 in Taylor, 198); patients find alternative ways of explaining disease compelling (Avina and Schneiderman, 1978 in Taylor, 204).

Below is a summary of the major reasons put forward for the popularity of complementary and alternative medicine:

1. Cultural pressures towards alternative and complementary medicine

Thomas Delbanco suggests that interest in alternative medicine is part of a general cultural tendency to retreat to an earlier, supposedly more natural and innocent past. Alternative medicine is a metaphor for purity and wholeness. Modern scientific medicine, he says, produces a proliferation of new and contradictory research findings (Delbanco, 1994, 803-

804). Ted Kaptchuk says “perhaps it is the unscientific belief systems of many of the alternatives that are the basis of their attractiveness. It may be that the persuasive appeal of alternative medicine is not the specific intervention but the context of expectation and expanded notions of self-identity in which these alternatives are embedded.” He adds that “most alternative therapies see ‘nature’ as the repository of virtue, purity, kindness, and wellbeing. Changing one’s life habits and taking ‘natural’ medicine provides an expanded sense of self-reliance, self-worth, and even meaning.” The illness becomes “a vehicle for an enlargement of the sense of self just when illness (or the threat of illness) is raising the spectre of human frailty and isolation” (Kaptchuk, 1996, 972). Astin hypothesizes, citing P.H. Ray (1997) that those who use alternative medicine are more likely to be involved in environmental, feminist, human potential or esoteric spiritual movements (Astin, 1998, May 20, 1549). Astin suggests that society’s growing interest in alternative medicine “may represent a type of cultural (Kuhnian) paradigm shift regarding health beliefs and practices” (Astin, 1553).

2. Consumer demand for personal medical care

We live in a consumer society. Patients have thought of themselves as consumers ever since the beginning of the patient’s rights movement of the 1960’s. Some take this one step further. It can be very frustrating to feel one has no choice in health care. This is particularly true in single-tier systems. In Canada, even those with the money cannot usually purchase better medical services. Modern medicine can seem like a monopoly on one form of treatment. By going to an alternative practitioner, the patient is saying to the medical system “you’re not the only game in town” and at the same time is gaining a sense of control. Many people may fear that the conventional medical system will turn them into dependent children or even victims. Alternatively, some may recognize that an underfunded system cannot give them help beyond basic care; they may feel they need more extensive and

personal attention. One of Astin's hypotheses was that people combined alternative and conventional medicine, or used alternative medicine exclusively, because they needed to have control over their health care. He thought that this group would find alternative medicine to be less authoritarian and more empowering. Although it is surmised that alternative medicine users want to control their own health care, this was not, according to Astin's study, a significant reason to use alternative medicine (Astin, 1998, 1548, 1550).

Increased immigration from countries which value other forms of medicine also contributes to greater use of alternative medicine. Ayurvedic (Indian) and Chinese medicine are held in esteem and are complete systems of medicine practiced (and, therefore, presumably tried and tested), for thousands of years. While practitioners of Indian and Chinese medicine may largely serve members of their own communities, their very presence in Western society reminds us that there is more than one way to healing. Even Western physicians are interested. The Tzu Chi Institute for Complementary and Alternative Medicine, affiliated with the Vancouver Hospital and Health Sciences Centre, is one example of cross-cultural exchange. Not only immigration but cultural awareness and respect has also led to Canadian interest in the healing methods of indigenous peoples. However, Manon Tremblay, the coordinator of Concordia University's Centre for Native Education, says that many First Nations people object to white Canadians appropriating their healing methods and, by extension, their culture (personal communication, February, 2001). Natives may have taught early settlers about the healing properties of plants but modern native people do not want outsiders approaching ancient and revered practices as if they were merely enticing consumer products in a New Age supermarket. Finally, immigrants from many cultures engage in various folk healing practices in the home. One student of alternative medicine suggested that it is conventional medicine that is alternative to people who have recently arrived from less developed countries (personal communication, February 2001).

Popular interest in alternative medicine may be the result of several trends in society: as well as the patient autonomy movement one can point to the failure of scientific medicine to cure disease (AIDS; cancer; antibiotic resistant diseases); fear of the side effects of conventional treatment (which was also an inducement to use homeopathy in the eighteenth century era of blood-letting and other draconian treatments); dissatisfaction with the mechanistic approach of biomedicine; inability, in state-funded medical systems, to have timely access to medical care and, in profit-making systems, to be able to afford medical care; the dehumanizing aspects of a modern underfunded state health care system.

3. Increase in the number of alternative practitioners

Fulder claims that alternative medicine is a genuine grass-roots movement (Fulder, 1996, 35). Taylor, however, notes that medical schools have become more difficult to enter and that those interested in medicine may turn to alternative schools (one hopes not as “second best”)(Taylor, 1984, 203). We cannot, therefore, say that the increase in alternative medicine’s popularity is solely due to popular pressure; it may be a function of the pressures of the market.

4. Dissatisfaction with the way conventional medicine is delivered

A popular belief has it that people turn to alternative practitioners because they are dissatisfied with the way in which biomedicine is delivered. Scholars like Fulder support this view (Fulder, 1996, 13). However, Ursula Sharma argues that dissatisfaction with the inadequacies of conventional medicine in an underfunded state system, not necessarily dissatisfaction with the theories of conventional medicine, accounts for this interest. Dissatisfaction is made up of “little discontents” (Sharma, 1992, 76). As Dr. Robert Buckman points out in *Magic and Medicine*, alternative practitioners often excel at

interpersonal relationships. It is also easier for them. A conventional physician is constrained by legal doctrines to disclose diagnosis and prognosis accurately.

Unfortunately, this often translates into: “we don’t really know what caused your cancer and I’m afraid it is so far advanced there’s not much I can do. Sorry.” (author’s quotes but see Buckman, 1993, 100-103). The alternative practitioner facing the same patient may say “clearly your *chi* energies have been out of balance for a long time. Yes, you are seriously ill but if you follow this dietary regime, meditate daily and come for your visualization sessions, you may well do just fine.” The conventional doctor is not permitted to imply hope where hope does not exist and cannot give clear explanations of a causality he does not understand. The alternative practitioner is able to give the patient something to do (meditate, diet) and attention (come back for visualization sessions). The oncologist will simply send the patient home referring her back to the GP or, ideally, to a palliative care specialist who can sometimes act in the same capacity as an alternative practitioner.

Patients complain of rushed and impersonal care; feel treated like a series of disease entities and not as whole people; fear the power of biomedicine to harm. A 1991 study by Sharma revealed a recurring theme: that conventional medicine treats symptoms only. Many patients in Sharma’s study were unhappy about being prescribed too many drugs which they felt were toxic (Sharma in Lewith, Kenyon, Lewis, Eds., 1996, 7). This is one very common reason proposed for the use of alternative medicine – it is perceived to be less dangerous, less invasive and more natural (a romantic view which ignores the dangers of unsterile or misplaced acupuncture needles, toxic herbs, unregulated practitioners and contaminated remedies).

As the authors and surveys cited above reveal, dissatisfaction with conventional medicine may not be the major reason behind the increased use of alternatives. A 1983 survey from

Southampton University, analyzed by Lewith and his colleagues, revealed that patients were happy with the care of their general practitioners and only two in the study avoided general practitioners entirely. The patients in his study said they went to alternative practitioners because their general practitioners could not treat their particular problem. They had every intention of returning to their GP's for other treatment (LeWITH, Kenyon, Lewis, 1996, 5-7). As the studies by Eisenberg and Astin show, people are more likely to use both conventional and alternative medicine at the same time. In Astin's survey, the few who relied solely on alternative care were the dissatisfied who represented only 4.4% of the survey. Astin suggests that future surveys should be designed to clearly distinguish those who use alternative medicine exclusively from those who use it as an adjunct (Astin, 1998, May 20, 1552).

People may be less dissatisfied with their physicians than with the hospital setting in which much health care is practiced. Striking staff, careless orderlies, dirty, overcrowded wards, clinics with broken-down furniture, peeling paint, long waiting times, threats of contamination from fungi and airborne bacteria and viruses, confusion because of hospital mergers, all contrast with the therapeutic calm and efficient service of many alternative settings.

5. Cure of chronic conditions

Alternative medicine is perceived to offer a gentler, kinder cure. British studies reveal that British patients go to alternative practitioners to cure conditions which orthodox medicine could not help or for symptom or pain control (Sharma in Lewith, Kenyon, Lewis, 1996, 7). As Sharma, Fulder and others have pointed out, many seek a cure for a chronic condition which has not yielded to conventional treatment or need quick relief for musculo-skeletal pain. These clients may not be aware of the philosophy behind the practice -- they simply

seek an end to discomfort or suffering, often with their doctor's blessing. Some may be unable to endure the lengthy waiting times to see a conventional doctor. In the UK (Liverpool) alternative therapies have been combined with a GP practice in a health centre. The GP's were delighted to be able to refer people with asthma, chronic pain, or fatigue, as were the patients at being referred. It was much cheaper than sending these patients to hospital for tests and reduced the burden doctors often feel when faced with patients they cannot cure. The only dissatisfied people in this arrangement were the alternative practitioners who felt they were expected to perform cures quickly without being given sufficient information. Many felt the doctors "dumped" these patients on them (Fulder, 1996, 91-93).

In Astin's study, symptom relief was reported to be the main benefit of alternative medicine. Many of his study's subjects suffered poor health and may have turned to alternatives because conventional medicine could not help. They may also, Astin proposes, be somatizers -- people who seek medical attention for symptoms with no pathological cause known to conventional medicine (Astin, 1998, 1552). In conventional medical practice, these people are frequently dismissed as hypochondriacs and pejoratively referred to as "crocks". Their medical charts might describe them as engaging in attention-seeking behavior. The treatment offered might range from "reassurance" to a psychiatric referral. Somatizing patients are naturally very sensitive to the impression that contemptuous judgements have been made. It is hardly surprising, therefore, if they turn to alternative practitioners who have more time to listen. Astin suggests that future studies distinguish between somatizers and non-somatizers (Astin, 1552). The difficulty here is that some diseases formerly seen as psychosomatic have turned out to be caused by viruses. Chronic fatigue syndrome is one such disease.

It is probably safe to say, therefore, that most people who use alternative medicine are not necessarily “true believers” in the alternative system.

6. True believers -- philosophic congruence

While people with chronic illness may not believe in alternative medicine’s theories of disease causation, which are often radically different from conventional medicine, some patients turn to alternative medicine out of a fundamental belief. These patients often have an internal locus of control, are active participants in their own care, and are more likely to benefit from it, according to Astin. In Astin’s study, those who exclusively used alternative medicine, revealed a more-than-average distrust of conventional doctors and health care institutions, had a profound need for control over their own health, and believed strongly in development of the “inner life”. It is this group that most profoundly distrusts conventional medicine and most strongly wants control over its own health care (Astin, 1998, May 20,1551-1552). With or without the blessing of their family doctors, they seek alternatives.

Some believe that we are entering an Einsteinian age of medicine in which the subtle energies that keep the body healthy will be recognized. Deepak Chopra is only one proponent of a medicine which is holistic in this broad sense. Some believe that we are moving towards a different type of Einsteinian universe in which energy medicine will predominate. In 1999, physician Larry Dossey published a book emphasizing his firm belief that medicine is now in its third stage (the first two being Era I, the mechanistic phase and Era II, when mind-body medicine first became popular). The physician Richard Gerber suggests that what he calls vibrational medicine will eventually replace the so-called outworn Newtonian model which focuses on objective facts and is a legacy of the experimental fervour of the Renaissance and the mind-body split of the Enlightenment (Gerber, 1988, 42-44). This is a New Age view that sees humankind advancing beyond

reductionistic, mechanistic science. Those who hold these beliefs are the philosophical descendents of the nineteenth century believers in vitalism. Kaptchuk and Eisenberg state that:

Biomedicine has a set of epistemologic assumptions that differ radically from those of alternative medicine [citing D.R. Gordon, 1988]. Alternative medicine's version of science lacks the recently adopted biomedical notion of clinical experiments carried out under artificially and deliberately controlled conditions, exemplified by the double-blind, randomized trial [citing T.J.Kaptchuk, 1998 and A.M. Lilienfeld, 1982]. Its version of science is observational and more closely resembles the modern sciences of paleontology and geology [citing S.C.Martin, 1994] (Kaptchuk and Eisenberg, 1998, 15 December, 1062).

They go on to say that :

Alternative medicine makes no rigid separation between objective phenomena and subjective experience. Truth is experiential and is ultimately accessible to human perceptions. Nature is not separate from human consciousness. Instruments that extend the senses or objective diagnostic or laboratory tests that discern what cannot be felt never replace human awareness. A patient never has to fear that an illness will be branded as existing 'only in their head.' A 'real' cause will be found for any sensation. The science of alternative medicine, unlike the science component of biomedicine, does not marginalize or deny human experience; rather, it affirms patients' real-life worlds (Kaptchuk and Eisenberg, 1998, 15 December, 1062).

The reality of medical practice is that much of it is nowadays focused on cure. Those who are not cured may seem to challenge conventional medicine's belief that it has all the answers. Much of the polemical literature attacking conventional medicine sees conventional medicine as made up of arrogant and self-aggrandizing individuals. This demonizing does not advance discourse. Doctors know that they cannot cure all ills and family physicians, in particular, may cheerfully refer patients to alternative practitioners because, for most, their goal is to help the patient, not to prove themselves right. It seems that many doctors and patients, therefore, may turn to alternative medicine not because they believe in its philosophy but for eminently practical reasons.

Alternative medicine gives people the opportunity to participate in their own cure and offers

a feeling of control and self-reliance. When one feels most frail, alternative medicine can give people a way to enlarge their sense of self.

7. Alternative and complementary medicine as a spiritual path or search for meaning

One must distinguish between confidence in a practitioner or practice and a belief in the practice's underlying principles. Some are satisfied with alleviation of symptoms but others seek from alternative medicine that which conventional medicine cannot offer: a sense of transcendence. They want their care to be a vehicle of transformation. These could be said to be the "true believers" in alternative medicine.

Meredith B. McGuire suggests that the continued popularity of healing systems, many of which have their origins in the nineteenth century (and some which date back to antiquity), is part of a larger social phenomenon which "typically involves a totally different definition of medical reality, an alternative etiology of illness, and a specific theory of health, deviance, and healing power" (McGuire, 1988, 5). She adds "that even the strangest, most difficult to understand healing beliefs and practices provide very important functions for their adherents: meaning, order, and a sense of personal empowerment in the face of upsetting or even traumatic experiences in life. Alternative healing systems", she says, "are meeting some people's needs, which the dominant medical system does not address. Thus they highlight some of the limits of modern 'scientific' medicine" (McGuire, 1988, 14). They are perhaps a protest against the type of Cartesian dualism which still dominates the medical landscape of the late twentieth and early twenty-first centuries. These systems offer meaning, order and personal empowerment. They answer what modern medicine, because it sees spirituality as outside its sphere of influence, cannot.

The concern for promoting medicine as a scientific rather than a religious or even magical enterprise has led many physicians to ignore the symbolic aspects of medical care. Some patients, particularly those who are very ill, may need to see the physician as possessing almost shamanistic powers and the remedies prescribed as having magical curative properties. The tenacity of these beliefs may survive many so-called rational explanations given to the patient in the name of the legal doctrine of informed consent. The doctor may say “ninety percent of patients are not cured by this type of chemotherapy” whereas the patient hears and clings to the idea that ten percent do well.²⁶

A popular view of biomedicine sees it as increasingly detached from the people it purports to heal. From its roots in mechanistic science, biomedicine is committed to the view that all diseases have causes which, once known, can be cured. Some think that the enduring belief

²⁶Ernest Rossi recounts the story of a man with advanced lymphosarcoma that did not respond to any treatment. However, an experimental drug, Krebiozen, became available in the centre where he was treated. The patient's disease was far too advanced for him to be eligible for this research treatment but he demanded it as his last chance. Against the rules of the ethics committee, his doctor injected him with the substance. After the first treatment, the man, amazingly, recovered. His tumours reduced to half their original size and the treatment was continued. Within 10 days, the signs of his disease had disappeared. From lying on his deathbed, attached to oxygen, he left the hospital and even flew his own plane.

Over the subsequent few months, data emerged to show that Krebiozen was useless. The patient read these reports, lost hope and relapsed. His doctor, out of a desire to see how “quacks” achieve results, decided to lie to him and tell him to ignore the newspaper reports. He told the patient that the drug he gave him had deteriorated but that he was about to receive a new, double strength version of Krebiozen. While he waited, the patient's hope grew. His doctor injected him with fresh water and the patient's recovery was even more dramatic than it had been with Krebiozen. He enjoyed renewed health and vigour and had no symptoms for two months. By now, the American Medical Association had pronounced Krebiozen to be worthless. The patient learned of this, relapsed and died within two days (Rossi, 1993, 4-7). This case raises an intriguing and troubling ethical question: if placebos are so powerful, can a physician lie to produce a good outcome? The patient's physician, Dr. Philip West, clearly thought the end justified the means but one might surmise that the patient, after learning of the AMA opinion, may have felt utterly betrayed. For faith to be so powerful as to revive the moribund, all contradictory evidence would have to be suppressed or explained away. But one might ask if the ethical demand that patients be told the whole truth about treatment sometimes works against hope and healing.

of biomedicine is that scientific research will eventually find a cure for all known disease. The focus is on the object -- the disease process observed in the patient. Many have pointed to biomedicine's Cartesian emphasis on the body as machine as the source of dissatisfaction. In the Newtonian world view, medical scientists hope that all known diseases can be discovered, mapped and cured. That is one reason for the popular appeal of "wars on cancer". The imagery of the body as a battlefield, and of biomedicine as the saviour that can root out and vanquish disease, is compelling to some. In contrast, many systems of alternative medicine emphasize holism more than does conventional medicine. What the patient experiences, Kleinman says, is described as the illness, as opposed to the disease process, which is observed by the doctor (Kleinman, 1980, 72-73).

Kaptchuk and Eisenberg say that many reject the dichotomy between science and religion, seeing "their truth with more unity and seamlessness." Kaptchuk and Eisenberg say:

In alternative medicine, the spiritual and physical domains provide different voices of the same cosmic anthem. Nature and vitalist forces are the 'technology' for regulating the secular-divine dispensation connecting the metaphysical and physical (Kaptchuk and Eisenberg, 1998, 15 December, 1063).

The authors cite a study of alternative medicine practitioners that compared 340 members of the American Holistic Medical Association with 142 Californian family practice physicians who were similar demographically. This study revealed that "the most statistically significant variable that distinguished holistic providers from conventional providers was the importance of 'religion or spiritual experiences' in their views of health, illness, and healing"(Goldstein, Sutherland, Jaffe, Wilson, Soc Sci Med, 1988; 26:853-61, cited in Kaptchuk and Eisenberg, 1998, 15 Dec, 1063).

However, Kaptchuk and Eisenberg seem to strain for analogies in their example of how

alternative medicine compares with religion: "Participants in alternative healing create a form of religiosity in their quest for health, although sometimes with less self-awareness. Vitamins, dietary supplements, and exercise regimens become daily activities of affirmation, assurance, and commitment" (Schafer and Yetley, 1975, cited in Kaptchuk and Eisenberg, 1998, December 15, 1063). "Dietary regimens, which can seemingly rely on brown rice or raw fruit juices, become liturgical acts of recognition with deeper implications for social, moral, and spiritual redemption" (Dubisch, 1981; Kandel and Pelto, 1980) in Kaptchuk and Eisenberg, 1998, December 15, 1063).

All routines can take on a religious quality but that does not mean that health regimes are like religion. What they have in common is that both religious and health leaders recommend daily routines that lead to self-improvement. And it is true, as Kaptchuk and Eisenberg suggest, that meditation or yoga, which are a means to transcendence, can become ends in themselves, focusing on bodily perfection. However, if humans are mind, spirit and body, Kaptchuk and Eisenberg have created false dichotomies. Individuals engaged in meditation and following vegetarian diets may be striving towards a type of *kenosis* in which they empty themselves of worldly attachment. Kaptchuk and Eisenberg, citing Turner and Whorton, see this as the attempt to gain "somatic perfection" (Turner, 1982; Whorton, 1977 cited in in Kaptchuk and Eisenberg, 1998, December 15, 1063). But this is a religious act and physical health is its byproduct, not its goal.

Robert Fuller, in *Alternative Medicine and American Religious Life*, speaks of the deeper appeal of alternative medicine when he uses the phrase "unchurched spirituality" (Fuller, 1989) to describe the ways in which people seek a more personalized experience of the sacred. This, he suggests, may be one important inducement to use alternative medicine. Fuller says that "metaphysical healing movements mobilize therapeutic resources that are

unlikely to be tapped in nonreligious ways” (Fuller, 1989, 128). Many people need to have their illnesses recognized and understood as a spiritual journey. Fuller suggests that the religious experience of the healing method used may have a therapeutic value distinct from healing methods which are alternative but non-religious (Fuller, 1989, 128). Healing rituals, he says, help individuals create structure for their encounter with the sacred (Fuller, 1989, 122-3).

One of the most devastating effects of illness is not only the illness itself but the loss of control and the feeling that the universe, once seemingly benign, has become malevolent. Metaphysical healing systems help individuals rise above the confining inexorability of the scientific doctrines of cause and effect, experiencing for a short time the power of the numinous (Fuller, 1989, 122) or at least a hope that the sacred will “fix what is wrong”. Illness is a serious threat to a person’s sense of safety within the cosmos. With its risk of personal annihilation, illness disrupts one’s comfortable familiarity with oneself. Thus any effective healing relationship must create a system of meaning in which the patient can still feel connected to and in harmony with forces that promote wellness. To feel connected to healing forces is, in itself, healing (Fuller, 1989, 134-135). Some types of alternative healing, by offering the client a total meaning system, make sense of the chaos of illness. The explanations of illness offered by alternative practitioners can seem more compelling than those offered by conventional doctors.

Because of biomedicine’s emphasis on truthful disclosure, the patient with an unusual disease may learn from his medical doctor only that his disease has no explanation. While possibly true, such an answer does little for many patients who would much prefer to situate their illness in a total system of meaning. Such a system creates a feeling of security and strength in the face of a universe which is precarious for all living beings. It is very difficult

to accept that one is ill without knowing the cause, whereas knowing the cause may help one to believe one can prevent future illness. Modern medicine tends to fail patients by not giving them a sense of control, not always giving them reasons for illness and by ignoring the ontological dimensions of illness. It is extremely difficult for individuals to cope with a universe which is random and which rains suffering on the just and unjust alike. Alternative medicine's appeal, according to oncologist Dr. Robert Buckman, is that it offers an overarching explanation for the experience of disease (Buckman, 1993, 94, 95, 103) and therefore is a type of theodicy.

Fuller believes that some types of alternative medicine can help people for whom religion has become dry connect to God or a divine being and therefore feel strong in the face of precariousness. By turning healing into a religious ritual, Fuller says, the client believes that she is in the process of being cured (Fuller 1989, 120). Secularization has not erased the need to believe in the divine, it has relocated it, he says. Some types of alternative healing practices are ideally situated to provide this type of religious meaning because they focus on the private and do not demand acceptance of past authorities (Fuller, 119). Alternative practices based on vitalist theories (these theories hold that the universe, and all that is within it, are charged with invisible, spiritual energies) are particularly appealing to those who seek in alternative medicine a source of spiritual sustenance. They are important in that they offer ritual to those for whom church rituals have become dead ritualisms. These rituals, all of which attempt to realign physical and spiritual energies, can be deeply satisfying.

Alternative healing practices differ not only from conventional religion, but from conventional medicine. Some types of alternative healing, particularly natural healing practices, can be seen as a collection of "procedures without discourse[,]...located in an area organized by the past" and occupying the place of a wild 'reserve' for enlightened

knowledge” (de Certeau, 1984, 65). They are an alternative source of power, difficult to regulate and, as such, are “tactics” with which individuals negotiate the space between their own cultural understandings of what offers relief from illness and the view imposed by the dominant biomedical system (see de Certeau, 49).

We could ask if those who turn to alternative healers seek in a “distant land” (in that many alternative practitioners occupy a world foreign to biomedicine) that which ostensibly exists in biomedicine but can no longer be recognized within that system (see de Certeau, 1984, 50). The power to heal is the claim of biomedicine, but as one physician put it, “I don’t want to be called a healer -- that sounds flaky” (personal communication, 1993).

The appeal of alternative medicine may well rest on some tacit assumptions people have about illness which they do not articulate either to themselves or their physicians. Illness may cause a crisis in moral meaning leading to questions about suffering which are older than Job -- “Why me? What have I done wrong? How can God let it happen?” For many people, illness falls within the purview of morally significant events. Some believe that their own or someone else’s illness is caused by wrong-doing, either their own or the other person’s. Others may ascribe it to an ancestral sin leading to a familial “taint” which causes genetically inherited illnesses. Ill people and those closest to them commonly engage in ritual acts which they hope will appease the powers of the cosmos. They may say novenas, engage in penances or pilgrimages. If they are not religious people, those faced with illness may feel that they or others are morally accountable for causing the illness. On a personal level people blame bad diet, alcohol or drug consumption and smoking. They may renounce bad habits, engaging in rigorous dieting or exercise programs. On a global level, they may hold chemical companies responsible for polluting the environment and causing illness. Alternative medicine, with its greater understanding of the spiritual

components of illness, its greater readiness to ascribe meaning to illness and its focus on the “natural” in diet and medical remedies, seems to provide answers about the causes of illness and suffering which satisfy believers and agnostics alike.

The dominant problems of our society -- a sense of meaninglessness, rapid social change, loss of relationships, job loss and workplace instability are all associated with illness. Fuller points out that when people who suffer in this way turn to alternative healing movements, they may enjoy an elevation in self-esteem. This is made possible by drawing the individual into a larger cosmos in which harmony between healer and sufferer mirrors and channels the harmony of the cosmos. If the client feels that divine energy flows between the healer and herself, between the healer and the cosmos and between herself and the cosmos, then the individual feels safe, contained and protected by benign beings or a benign universe. By forming a relationship with God or a superior being one can feel strong within oneself, even in the face of a precarious personal or social world (Fuller, 1989, 133-138).

Conclusion

The types of patients who turn to alternative medicine may be the healthy, who feel tired and stressed and look for greater “wellness”; those with self-limiting illnesses (taking echinacea for mild ‘flu is the most typical example); the chronically ill for whom conventional medicine can do little and who may feel treated as malingerers in this system; those with serious illness who go to conventional medicine for diagnosis and alternative medicine for cure; those with serious illness who use alternative medicine to alleviate side effects; those who find in an alternative practice a spiritual path.

It seems that several factors account for interest in alternative medicine: cultural pressure; consumer demand; increase in the number of practitioners available; dissatisfaction with the

dehumanizing aspects of the modern underfunded health care system, with the medical encounter, or with side effects of conventional medicine; treatment failures of chronic conditions in conventional medicine; belief in alternative medicine; need to have one's illness recognized and understood as a spiritual journey. The two chapters in the next section will look more deeply into healing as a spiritual journey.

Part Three

Complementary and Alternative Medicine: Historical Antecedents; Religious and Spiritual Influences

Part Three - Introduction

Complementary and Alternative Medicine: Historical Antecedents; Religious and Spiritual Influences

A rich and variegated tradition of folk medicine lies behind some of the practices of complementary and alternative medicine. Over the centuries, continually shifting boundaries have divided official from folk or popular healing. What has remained constant is the often uneasy relationship between established and folk practices. From an ethical perspective, what is important to keep in mind is a type of objectivity that demands that each form of healing be approached and studied for its own intrinsic value. Excessive criticism of folk practices is as unhelpful as unbridled enthusiasm for conventional medicine. History reveals that yesterday's orthodoxy is often today's heresy.

Healing and religion have been linked since antiquity. Wouter Hanegraaff says it may be modern medicine that is alternative when we look at it through the prism of the history of religion. Hanegraaff devotes a chapter of his work, *New Age Religion and Western Culture*, to healing which, he says, is very much a part of the New Age movement because of the New Age emphasis on personal growth and deliverance from suffering (Hanegraaff, 1998, 46). He links the Holistic Health movement with the Human Potential movement and states that a major characteristic of Holistic health is the importance of the mind in healing the body (Hanegraaff, 53-54).

The religious or spiritual component of alternative medicine is alluded to but insufficiently analyzed in much of the conventional literature on alternative medicine. This may be due to the inability of conventional medicine and science to address spiritual issues. Some writers

mention spirituality as if it were peripheral to alternative medicine, rather than functioning at the core of many alternative healing practices. Recent articles and conferences on alternative medicine tend to focus on that which can be measured -- products like herbs or specific techniques such as moxibustion -- and shy away from the spiritual context of some aspects of herbal medicine (the spiritual resonances of flowers in the Bach flower remedy system).²⁷ Consumers, likewise, often bring the mindset of conventional medicine to alternative practice. Modern drugs are accurately targeted. Losec will eliminate heartburn; Ativan will calm. People accustomed to the quick action of conventional drugs may expect herbals to work in the same way. They may go to a naturopath to seek relief from the side effects of chemotherapy and have no interest in any spiritual beliefs in which a practice or remedy is grounded, for example the suggestion that current problems may be traced to events in a past life.

This chapter and the next will serve as road-maps to the ideas and the movements in modern types of complementary and alternative medicine that have been influenced by religious and/or spiritual beliefs.

Chapter five will look at important historical figures and movements that had an influence on the development of forms of medicine and healing now viewed as alternative. Reiki, Therapeutic Touch, the channeling of healing spirits, the use of crystals and stones to draw healing power into a room or a diseased limb, even the idea of an invisible and undetectable energy in a homeopathic pilule -- all are techniques with roots in very ancient ideas. Chapter five will focus not so much on whether a practice is "religious" or not, but on ideas and

²⁷However, the November 1999 University of Pennsylvania School of Medicine conference, *Complementary and Alternative Therapies in the Academic Medical Center: Issues in Ethics and Policy*, presented three talks on this topic in a section titled *Spirituality, Religion and Ritual*.

practices that might help established medicine to learn about healing methods that can enhance health and well-being.

Chapter six will introduce some sociological theories about religion and its role in healing, will examine complementary and alternative medicine as a spiritual path in a secular world, present a short history of the spiritual and religious ideas important to a consideration of twentieth and twenty-first century healing movements and will conclude with an examination of some of the specific ethical problems that arise when methods that purport to be value-free healing techniques are, in fact, implicitly religious.

Chapter Five

Historical Antecedents of Complementary and Alternative Medicine

Introduction

Medical histories tend to be written in a linear fashion, emphasizing the idea of progress (Delaporte, 1994, 140). Although this chapter will trace the historical antecedents of alternative medicine in a similar fashion, it will keep in mind Foucault's contention that medicine's history is discontinuous, in spite of a popular belief that it demonstrates progress from the time of Hippocrates and Galen. In *The Birth of the Clinic*, Foucault granted "primacy to discontinuity", according to Delaporte. If the clinic has been "born", in Foucault's words, Delaporte says, then what went before has died. It may be intellectually satisfying to see history in terms of "continuities, anticipations, and rudimentary precursors" -- to see Hippocrates "as the eternal source of all medicine"; to see modern forms of alternative medicine as a rediscovery of the past. Better than to search for origins, Foucault's method proposes, is to "search for beginnings, the given with the constructed, the continuous with the discontinuous." The approach taken by Foucault, as explained by Delaporte, is archaeological: "Where historians see boundaries or cracks that must one way or another be filled in by restoring continuities, the archaeologist sees ruptures and differences to be explored in depth" (Delaporte, 139-141).

All of the above is important to an understanding of any relationship between past healing rituals and present alternative medical systems. What may, on the surface, appear to be a continuity may, at the level of belief be a discontinuity. The twenty-first century woman who wears a copper bracelet for arthritis will probably not attribute numinous power to "sacred"

metals in the same way as her Anglo-Saxon forbears. The deep meanings of specific healing movements change over time. Alternative medical practices still popular in twenty-first century North America may appear to be the direct descendents of movements found much earlier in history. But, as Foucault said, the meanings of institutions change over time. We may find that that which seems familiar has “forgotten, accidental, and possibly ignoble antecedents” (Urmson and Rée, 1960, 1989, 112, referring to Foucault’s 1977 work *Discipline and punish: the birth of the prison* and see Foucault [interview] in Gordon, Ed., 1977/1980, 112). A danger exists, when comparing the religious or healing phenomena of one century with apparently identical phenomena of another, of drawing false connections (see H.Geertz, 1975, footnote 17, 84 and footnote 20, 85). Nonetheless, the deep underlying structures of such phenomena can sometimes be similar or even identical. They may be grounded in the simple desire of all humans to alleviate pain and cure sickness.

This chapter will look at beliefs about how healing works, look at modern historians’ opinions about popular versus elite understandings of religion and medicine and then present an historical overview of practices which, on first sight, appear to be antecedents of modern alternative medicine. Some were orthodox in their day; others were heterodox, even in their time. We must ask whether twenty-first century alternative healing rituals and practices represent survivals, continuities or discontinuities. One may also ask why, given the scientific advances of the twentieth century, sick people would consult practitioners of folk or alternative medicine or engage in healing rituals? What needs are being answered by homeopaths, iridologists, crystal healers, herbalists and practitioners of Therapeutic Touch that seem not to be answered by medical doctors, and are these needs different from the needs of our ancestors? Why, in a supposedly scientific age, especially in countries like Canada where health care is free, would individuals choose to go to alternative healers who may have little training, be unlicensed and unaccountable to any official licensing

organization? Why, in a modern scientific age, would people turn to forms of healing which seem more religious than scientific? What are alternative healers able to offer that is absent in conventional medical care?

Medicine has the power to define illness, often labelling as disease that which it considers to be outside acceptable social norms. Before the abolition of slavery in the United States, a disease called drapetomania was identified. Drapetomania was the diagnosis of a slave who wanted freedom (Dally, published in Porter, Ed., 1997b, 59). Clearly, medical opinions can rest as much on assumptions about the nature of human beings as they can on the findings of hard science. Political scientist Fred Frohock, citing an interview with a psychiatrist, points out that before we make disparaging comments about alternative modes of healing we should remember that within the last fifty years portions of the brains of people with schizophrenia were destroyed to “cure” them when no clinical trial had ever proved this surgery to be efficacious. Thousands were maimed or died (Frohock, 1992, 136). The history of medicine is littered with “cures” which now seem as magical, in the pejorative sense, as the so-called magic against which conventional physicians rail. Therefore, before looking at the history of healing practices and practitioners, a short discussion of beliefs about illness is in order.

Beliefs About Illness, its Cause and Cure

Magical beliefs about illness

Pliny, a first century CE scholar whose *Natural History* is an extraordinary compendium of all the natural objects in the world, believed that magic had its origins in medicine, creeping in by pretending to improve health and claiming therefore to be a higher type of healing (Pliny, Healy, Trans., 1991, Book XXX #2, 268). Pliny was no friend either of magicians or doctors: “Some gravestones”, he said, read “a gang of doctors killed me” (Pliny, 1991,

Book XXIX, # 11, 263). Pliny saw magic as seductive in the same way that religion is (Pliny, 1991, Book XXX #2, 268). He spoke of the use of ligatures in healing²⁸, condemning them as did Eligius in the seventh century, even when, in Eligius' time they contained Christian prayers (Pliny, Book XXX, xxx, 98-101, Jones, Trans., 341-345; Flint, 1991, 244-246). From the seventh to tenth century, ecclesiastical condemnation tried to attenuate the popular belief in magic.

Magic can be divided into natural magic and demonic magic. Natural magic was considered to be a branch of science and was not called magic before the twelfth century. By the thirteenth century some began to view natural magic as an acceptable alternative to demonic magic (Kieckhefer, 1989, 10-14). Yet even before the twelfth century, natural magic could come under suspicion, and churchmen often had misgivings about claims for the naturalness of certain practices. Pagans might say they were merely exploiting the natural power inherent in certain stones or herbs, but demons might, in the view of the official church, be involved. Augustine of Hippo's (born CE 354) ideas on this point were influential. Augustine spoke of and accepted magic hidden in nature although did not use the term magic. He condemned magic, all of which, he believed, was exercised through the power of demons (Augustine, 1st pub 1467 Bettenson, Trans., 1972 & 1984, Book VIII, Chapter 19, 325-326 and see Kieckhefer, 1989, 38-39).

Until the eighteenth century, beliefs modern people might call "magical" were accepted by peasants and kings. These beliefs included: (1) the idea that disease could be transferred to objects. A typical ritual might involve touching warts with a pebble and burying the pebble. (2) The belief that a sick person could transfer his/her disease to a dead body.

²⁸Ligatures were strips of cloth or leather, often inscribed with magical or sacred verses, and tied round an arm, leg or whatever part of the body was injured.

Consequently, grisly as it might seem, a person might bring a sick child to touch the arm of a thief hanging from the gallows. (3) the doctrine of signatures, in which the morphology of plants indicated their application (Porter 1997a, 281-282).

Beliefs in the etiology of illness were also susceptible to “magical” interpretations. People attribute illness to many sources which may not, at first glance, seem plausible. Modern people often focus on the nebulous “stress” as an explanation for cancer, cardiac disease and skin ailments. Explanations of the etiology of illness, according to Porter, include “notions of blame and shame, appeasement and propitiation, and teachings about care and therapeutics.” Some societies see illness as caused by “ordinary activities that have gone wrong -- for example, the effects of climate, hunger, fatigue, accidents, wounds or parasites.” Other societies see supernatural agencies at work: a sorcerer may use magical spells; a witch might inadvertently cause illness; illness might be caused by someone who is ritually impure -- a menstruating woman for example. If illness injured, then its cause was seen as aggression from outside sources (Porter, 1997a, 33). For example, in the early Middle Ages, some thought that disease was caused by “elf shot”²⁹. Bald’s Leech Book, a mid-tenth century medical text, offers the following cure for livestock shot by an elf: “If a horse or other cattle is [elf] shot, take dock seed and Scottish wax and let a man sing twelve masses over [them]; and put holy water on the horse or cattle. Have the herbs always with you” (Jolly, 1996, 1). Anglo-Saxon scholar Karen Jolly points out that such charms are an example of the assimilation of Christian ideas about spiritual and physical well-being. Pagan belief in elves was accommodated within a Christian worldview which included demons and therefore Christian charms against elves were devised (Jolly, 2-3).

²⁹Elves were the snipers of the spiritual world. They were believed to be lower spirits who lurked in bushes and shot their victims with arrows which either wounded or caused disease.

Even in the early seventeenth century, the professor of medicine Daniel Sennert (1572-1637), who had studied under Paracelsus, combined Paracelsian teachings with Galenic humorilism³⁰. Sennert believed “sickness was the result of an accident affecting the soul or vital powers of the body, impairing its normal organizing power and resulting in pathological disruption” (Porter, 1997a, 207).

Scholars divide these theories into the “*mystical*, in which illness is the automatic consequence of an act or experience; *animistic*, in which the illness-causing agent is a personal supernatural being; and *magical*, where a malicious human being uses secret means to make someone sick” (Porter, 1997a, 33-34). Philologists J.H.G. Grattan and Charles Singer (1952) claimed that people in the Anglo-Saxon era and Middle Ages were ignorant and did not understand the causes of disease. Audrey Meaney argues convincingly that, far from being ignorant and deluded, the people of the tenth century had a logical and coherent explanatory system. The belief that disease comes from outside (in the form of elf-shot) is not so different from modern perceptions about illness caused by the environment (Meaney, 1992, 24-25 and see Flint, 1991, 115).

Even modern societies engage in forms of witch-hunts when they periodically become convulsed with fears about invisible contaminants such as electromagnetic rays or genetically modified foods. Although we would not usually describe these as magical

³⁰For two thousand years, humoral doctrine influenced medicine. Empedocles, a Sicilian philosopher (died after 444 BCE), is presumed to have been the first to suggest the idea of the four humours. Hippocrates (460-377 BCE) and Galen (129-216?CE) applied the idea to medicine. Empedocles described four elements -- fire, water, earth and air. Hippocrates believed that these elements were represented in the body by the four humours -- yellow bile (fire), phlegm (water), black bile (earth) and blood (air) -- with the corresponding temperaments: choleric, phlegmatic, melancholic and sanguine.

theories, levels of suspicion about invisible enemies may take on a magical quality. The usual targets of popular wrath are governments that permit contaminants to enter air, soil or water or industries that pursue profit at the expense of individual health. While these are probably fair assessments, fears of contaminants lend themselves to conspiracy theories of a decidedly “magical” nature.

Up to and even beyond the seventeenth century, belief that illness was caused by bewitchment was common. This was even accepted as a diagnosis in the seventeenth century by physicians unable to explain the cause of illness. It could be used to explain why a patient died. This may have been a conveniently tempting explanation not only for incompetent physicians but for official churchmen and even witch-hunting villagers. They may, from time to time, have needed a way to explain illness and death that followed the ministrations of a village cunningman or woman (Thomas, 1971, 639-640, 586) as the Church was opposed to those who went to cunningfolk to reverse spells causing by illness, seeking out countercharms.

Porter points out that traditional beliefs see health as “a state of precarious balance... . More important than curing is the aim of preventing imbalance from occurring in the first place. Prevention lies in living in accord with nature...and the supernatural powers that haunt the landscape: purge the body in spring to clean it of corrupt humours, in summer avoid activities or foods which are too heating” (Porter 1997a, 39). Many forms of complementary and alternative medicine -- Therapeutic Touch, homeopathy, Reiki, attempt to restore the balance of the body’s energy as a prevention against illness.

Medical beliefs about illness

Anthropologist Stanley Tambiah says that:

a commitment to the notion of nature as the ground of causality, of nature as a uniform domain subject to regular laws, can function as a belief system without its guaranteeing a verified 'objective truth' as modern science may define it. In other words, the appeal to 'nature' or 'science' can serve as a legitimization of a belief and action system like any other ideological and normative system (Tambiah, 1990, 10).

Tambiah points to such tragedies as nuclear reactor accidents as one example of "our victimization on the altars of innocent belief in science..." (Tambiah, 1990, 10). He partially quotes Foucault: "Truth," he says, "is centred on the form of scientific discourse and the institutions which produce it; there is a constant economic and political incitement to produce this 'truth'." Our society accepts the discourse of science and "makes [it] function as true" (Foucault, 1977/1980, Gordon, Trans., 131-132; Tambiah, 1990, 147). All too often it is as much a reification of illusion as what some scientists call magic.³¹

Daniel P. Eskanizi, DDS, PhD, LAc, writing in the November 11, 1998 issue of the *Journal of the American Medical Association*, says :

As it has not been scientifically demonstrated that "physical matter is the only reality," materialism, therefore, is akin to a religion, ie, "a system of beliefs held to with ardor and faith"(citing the 10th edition of Merriam-Webster's Collegiate Dictionary). Western allopathic medicine would, therefore, have the same fundamental quality as traditional systems of health: it reflects the dominant philosophical belief system of the society in which it developed (Eskanizi, Nov 11 1998, 1622).

Meredith McGuire points out that the medical reality promoted by the dominant biomedical culture is not "necessarily the 'true' reality" but one of many ways of conceiving "of

³¹Foucault's text reads: "'Truth' is centred on the form of scientific discourse and the institutions which produce it; it is subject to constant economic and political incitement (the demand for truth, as much for economic production as for political power); it is the object, under diverse forms, of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body, notwithstanding certain strict limitation); it is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media); lastly, it is the issue of a whole political debate and social confrontation ('ideological' struggles)" (Foucault, Gordon, Trans., 1977/1980, 131-132).

illness, its causes, and treatment. Medical reality...is socially constructed” (McGuire, 1988, 5). Medical anthropologist Arthur Kleinman says that “Health care systems are socially and culturally constructed. They are forms of social reality” (Kleinman, 1980, 35). He views medicine as a “ cultural system, a system of symbolic meaning’s” which include beliefs about illness, its causes, its treatments and the “socially-legitimated” relationships, roles and power structures of institutions (Kleinman, 24). McGuire points out that all healing systems have an implicit ideology, saying that when doctors legitimate therapeutic failures, they justify their decisions and actions and protect their power (McGuire, 36). She says:

The dominant medical system in this culture is based upon... an implicit belief system regarding the nature of illness and its sources, healing power and its sources, legitimations for failure and so on. In particular, Western biomedicine tends to view disease as a process devoid of social, human value or meaning components. The human body is treated as an object separate from its social, emotional, and other environmental contexts. Disease is often...reduced to a specific occurrence that simply ‘happens’ to an individualized physical body...(McGuire, 1988, 36).

That this can be very distressing to patients is illustrated in the story of a physician who injured his leg. He felt depersonalized when the admitting doctor “insisted he limit the ‘history’ of his injury to ‘salient facts’ -- particulars relevant only to the physical injury itself.” Yet the injured physician felt his injury was part of a larger story of being saved from near death at the last moment. Conventional medical practice leaves little room for this type of meaning (McGuire, 1988, 241). McGuire attributes this mechanistic attitude to doctors but health-care systems are probably more responsible. It is difficult to imagine any emergency room physician having time to explore with the patient his view that illness is a part of his life’s narrative.

Magic, religion and science

Magic and religion, says Richard Kieckhefer in a summary of Stanley Tambiah’s *Magic*,

Science, Religion and the Scope of Rationality, represent alternative forms of rationality, distinct from science, "...ordering reality according to participatory rather than causal principles." Looked at from this perspective, even sophisticated scientists might find rational sense in practices we sometimes define as "magical" (Kieckhefer, June 1994, 813-814).

Alternative medicine, like popular religion, has always had its critics who attack it because it engages in "magic" and seduces the vulnerable and credulous. The definitions of what is considered to be magic and what is considered to be science shift from century to century and culture to culture, a theory Karen Jolly expounded in her discussion of popular and formal religion (Jolly, 1996, 19-27). As Hildred Geertz said in a review of Keith Thomas' *Religion and the Decline of Magic*, "the grounds upon which these beliefs were to be dismissed [as magic]" are unstable, both from "person to person and from era to era" (Geertz, 1975, 75).

Those who elevate science and rationalism above that which is experienced (and therefore without discourse) have often developed theories to explain away religio-magical beliefs rather than seeing them as a rational response to illness. Folk and alternative medical beliefs may differ greatly, Hufford says, from the beliefs of conventional medicine but, within their own frame of reference, they make sense. Situated in their cultural context, popular practices may reveal an eminently coherent and logical ontology which we would call belief, not magic (Hufford, 1998, 260, 256-257). While alternative practitioners may offer modern people a sense of control when modern medicine leads them to feel out of control, this somewhat reductionistic explanation does not tell the whole story. The inherent logic of some highly elaborated forms of alternative healing may appeal precisely because of their apparent precision and ability to offer the sufferer one overarching and intellectually

satisfying explanation of the cause of his illness (see Buckman, 1993, 83-86).

Fuller points out that many Americans

subscribe to beliefs that belong neither to science nor to the more genteel theologies of our mainstream churches. By contradicting what might be called the “monistic materialism” underlying medical science, practitioners of unorthodox medicine become defenders of a point of view that by “official” cultural definition should be considered irrational and superstitious. Yet, strictly speaking, any medical system is rational insofar as its methods of treatment are logically entailed by its fundamental premises or assumptions about the nature of disease (Fuller, 1989, 6).

Fuller continues this argument by saying that those who hold to a supernatural view of healing are not less rational than those who believe solely in medical science; they are, however, “advancing a metaphysical claim concerning the existence of causal forces not recognized by contemporary scientific theory” (Fuller, 1989, 6).

Much folk and alternative medical belief has been associated with nonrational religious beliefs and some scholars have divided ideas about healing into two categories: (1) the “natural”, “rational” or “empirical” , which scholars took to include “herbalism, massage, bone setting, and other physically based therapies” and (2) the “irrational” or “magico-religious” (latterly called “non-rational” so as not to offend various ethnic groups). The so-called irrational or magical practices include charms, distance healing, the laying on of hands and other healing techniques which do not, from the point of view of science, have a so-called “real” basis to explain cures. Scientists usually attribute cures from such practices to the placebo response (Hufford, 1988, 255). In the category “irrational’ practices”, one could also include Christian healing, metaphysical healing and occult healing groups. Homeopathy, insofar as it continues to believe that the energy of healing substances can be transferred to liquids or pills when those remedies contain nothing of the original product, could also be described as nonrational. One must note here

that some so-called rational practices may incorporate heavy doses of “magic”. For example, bonesetters may use incantations and herbalists, charms. Conversely, the “irrational” practice of laying on of hands may have a physiologically-based explanation for its efficacy.

Many analyses of the manner in which these healing systems work point to people’s need for group identification, need to feel powerful and in control, need to reduce anxiety. Keith Thomas also used this argument to explain why magic declined as humans felt more in control of their environment (Thomas, 1971). “Unfortunately” as Hufford points out “this approach is often flawed by the false assumption that patterns of thought that reach fundamentally different conclusions from those of modern science must be, by definition, illogical, irrational, or even nonempirical. Such assumptions,” he says, “implicitly equate ‘rational’ and ‘empirical’ with ‘true’ and ‘correct’.” Observation, however, is at the base of both conventional and alternative healing. The theories of those who reject alternative healing on the grounds that its practitioners reason wrongly “serve more as a rhetorical defense of orthodox practice than as an aid to understanding the dynamics of other systems,” Hufford says. While folk and alternative practitioners begin with different assumptions, and use different criteria in diagnosis, their healing methods proceed according to a particular way of reasoning and they are based on observation (Hufford, 1988, 255- 256). Nonetheless, it is probably true that alternative healing rituals are a way of expressing a need to incorporate illness into a wider system of meaning. People who consult alternative healers ask not only “will it work?” but “will I feel less frightened and more in control of my body and my life?”

All of these ideas reflect a continuing struggle between ideas about what is magic, what is religion and what is science. To separate healing practices and beliefs into these hardened

categories makes understanding difficult.

Popular and Elite Religion; Popular and Elite Medicine

In some ways, alternative medicine is a form of popular medicine -- what is practiced, rather than prescribed, in the words of Natalie Zemon Davis (Davis, 1982, 322).

Popular and elite religion

An understanding of the way in which historians have understood and interpreted popular and official religious beliefs and practices is applicable to an understanding of the way in which alternative medicine is understood in relationship to orthodox medicine. Whereas past approaches forced official and unofficial beliefs into an often unnatural opposition, modern historians attempt to find common ground.

Popular religion, as described by historian Karen Jolly, is:

a modern construct used to examine one facet of a larger, complex culture. This construct has greater breadth and depth than the traditional approach that examines the formal church. Popular religion consists of those beliefs and practices shared by the majority of the believers. Rather than being a separate, opposite phenomenon from elite or formal religion, it embraces the whole of Christianity. Its inclusivity encompasses the formal aspects of the religion as well as the general religious experience of daily life (Jolly, 1996, 18).

Earlier scholars attempted to make a sharp distinction between orthodox "approved" religion and the religion of the people. To them, Anglo-Saxon use of holy water as protection against elf-shot, for example would be suspect -- evidence of an imperfect understanding of the then-new Christian religion. Philologists Grattan and Singer puzzled over the "barbaric" survivals mixed in with Christian prayers (Grattan and Singer, 1952, 7-

16).³² Similarly, some see the use of highly diluted homeopathic remedies as evidence of an antiquated magical world view and physician-prescribed remedies as orthodox.

Popular and elite medicine

Applied to medicine, one might say that orthodox medicine, like orthodox religion, is part of a much larger field which includes all beliefs about healing. Modern medicine may seem to be dominant, as the Church itself was in the early and late Middle Ages. But modern medicine is part of the culture in which it is situated and participates in its folkways. So-called commonsense beliefs about health-seeking and health-preserving practices (seeing a doctor for arthritis; getting an annual check-up; submitting to screening for genetic diseases) is part of a culture that claims that such practices will prolong or enhance life. Earlier generations would have put up with the aches and pains, couldn't afford to see a doctor once a year and would have no way of proving definitively that a disease was inherited. Physicians, like the clergy, preserve ways of knowing; patients engage in ritual acts to preserve and enhance health. An annual check-up is a ritual that may have no bearing whatsoever on longevity but may enhance feelings of security. Patients, likewise, may discover from a screening test that they are vulnerable to a breast cancer. They may act on

³²Jolly describes a field-blessing ceremony which uses Latin Christian prayers and has the celebrants turn three times with the sun and then lie upon the ground, reciting more Christian prayers. The ritual ends with an appeal to "earth's mother". The celebrant then takes a baked loaf, kneads it with milk and holy water and places it under the first ploughed furrow. Prayers are addressed to the "Field full of food for mankind,/bright-blooming, you are blessed/ in the holy name of the one who shaped heaven/ and the earth on which we live;/ the God, the one who made the ground, grant us the gift of growing,/ that for us each grain might come to use". Then further prayers in Latin are said (Jolly, 1996, 7-8). Jolly points out that this ritual is not pagan but was created by clergy of the official Saxon church. She argues that such charms are not "Christian magic" but evidence of Christianity's success in converting people by accommodating Anglo-Saxon culture (Jolly, 9). In the words of Aron Gurevich, these acts are not "petrified survivals" (Gurevich, 1988, 91), but part of a vigorous continuity. Parishioners would be aware of practices, like tree worshipping, that were proscribed and those, like herb-gathering and reciting the paternoster, that were meritorious (Gurevich, 97, 83; see Jolly, 1996, 26).

this knowledge by turning to formal medicine for a Tamoxifen prescription or opt for the presumably less toxic prophylactic remedies found in popular or alternative medicine.

What is considered popular and what is seen as formal can shift over time. Scholastic philosophy and theology created a gap in the twelfth century between popular and official religion. Some practices which had been accepted suddenly appeared absurd. Scholastic philosophers separated natural from supernatural which led to the identification of some types of healing rituals as “unnatural or magical”. Before this time, according to Jolly, these distinctions did not exist “and the line between formal and popular was much more fluid.” The Mass was a particularly important source of healing rituals. Herbs for healing might be kept under the altar and liturgical prayers, rituals and the Mass itself used for healing. Consecrated hosts were procured and healing prayers written on them before they were consumed. Modern scholars have called this “magic” and liturgists “shuddered at the degradation of a ‘pure’ liturgy that in reality came into existence only later” (Jolly, 1996, 26, 122, 114).³³

Eventually, Roy Porter points out, folk or “magical” medicine came under attack from the elites who tried to discredit it. When the attacks succeeded and popular medicine no longer threatened elite medicine, scholars became interested. In the nineteenth century, books compiling “medical folklore” and “medical magic” emphasized the “quaintness” of the formulas and rituals (Porter, 1997a, 37). A similar pattern appears to be occurring now. Alternative medicine was discredited in the nineteenth and early twentieth centuries. Once biomedicine triumphed and alternative medicine was no longer a threat, scholars in the last

³³The Mass is still used for healing. For example, a Roman Catholic priest in Montreal, Québec, celebrates regular healing Masses. At one attended by the author, he prefaced the opening prayers with injunctions against any spells, curses or demons that might be binding anyone present (St. Ignatius of Loyola Parish, NDG).

decade of the twentieth century began to examine it for valuable insights and new cures.

Porter emphasizes that in societies with elite and popular cultures “there has always been complex two-way cultural traffic in knowledge, or more properly a continuum. While often aloof and dismissive, professional medicine has borrowed extensively from the folk tradition.” As one example, he mentions smallpox inoculation that originated in “folk awareness.” Thus, says Porter, one must not assume antagonism between “the scientific and the superstitious”. The various types of healing might be practiced or resorted to by one person (Porter, 1997a, 39-40). The current interest on the part of conventional medicine in alternative medicine is a similar movement.

Popular beliefs about healing, Porter says, have their own logic:

Popular medicine is based upon coherent conceptions of the body and of nature, rooted in rural society. Different body parts are generally represented as linked to the cosmos; health is conceived as a state of precarious equilibrium among components in a fluid system of relations; and healing mainly consists of re-establishing this balance when lost... . Traditional medicine views the body as the centre or the epitome of the universe, with manifold sympathies linking mankind and the natural environment. Analogy and signatures are recurrent organizing principles in popular medicine. By their properties (colour, form, smell, heat, humidity, and so on) the elements of nature signal their meaningful associations with the human body, well and sick. For instance, in most traditional medicine systems, red is used to cure disorders connected with blood; geranium or oil of St. John's wort are used against cuts. Yellow plants such as saffron crocus (*Crocus sativus*) were chosen for jaundice... . Sometimes it was argued that remedies had been put in places convenient for people to use. So, in England, the bark of the white willow (*Salix alba*) was valued for agues, because the tree grows in moist or wet soil, where agues chiefly abound....(Porter, 1997a, 37-38).

Healing Beliefs and Practices from the Anglo-Saxon Era to the Twentieth Century

Many modern healing practices appear to be rooted in antiquity. While some -- astrology for example -- are ancient, others are modern expressions of an age-old need to tap into the

source of healing power when conventional methods fail. Following is a summary of major historical trends in healing. In later centuries, these ideas travelled to America where they took on the unique combination of American Puritanism, pragmatism and optimism. Americans enthusiastically founded healing churches and embraced and improved on ancient healing rituals in a search for earthly perfection and eternal salvation.

Anglo-Saxon Period and Middle Ages

Rituals -- magic and miracles

Innumerable prayers, incantations and practices are described in several leechbooks from the tenth and eleventh centuries. Keith Thomas makes clear the fact that these were still used right up to and beyond the seventeenth century. Healing rituals could include saying prayers or charms (or prayers as charms) over herbs; reciting the Paternoster or Ave Maria nine times (a magical number); reciting the Jordan Prayer (“as Christ stopped the Jordan, staunch this flow of blood”, see Kieckhefer, 1989, 71) which takes an event in scriptural history (a mythical event could also be used) and uses it in present time; inscribing sacred words on paper and dissolving them in water or ale and drinking them; using relics as amulets; taking dust from a pagan shrine or a saint’s tomb and drinking it in water; tying herbs or written charms to the sick person or hanging them about one’s neck as an amulet; burying hair or blood in the ground; bleeding a person and mingling the blood with water cast into a south-flowing stream (Thomas, 1971, Kieckhefer, 1989, Grattan & Singer, 1952; Meaney, 1992; Duffy, 1992). In many of the Christian charms found in *Lacnunga*, the presence of a mass-priest is required for the ritual (*Lacnunga*, Grattan and Singer, Eds, 1952, 16). Anglo-Saxon rituals might require that the ointment or potion be mixed in communion vessels. Popular devotion and beliefs also inspired people to write prayers or charms on the presumably unconsecrated host (see Kieckhefer, 1989, 79-80; Flint, 1991,

316). Clearly, the cooperation of the official church was necessary if some of these rituals were to be performed correctly.

By the tenth and eleventh centuries, efforts were made to exclude pagan practices. This was a transition period in which Christianity was firmly established in England but threatened by settlements of pagan Scandinavians in the Eastern part of the country. By the twelfth century, scholasticism led to a distinction between the natural and the supernatural, a distinction not found earlier (Jolly, 1996, 32, 26, 80).

However, miracles were always acceptable. The Eucharist is important in any discussion of miracles. Unlike sacraments received only once in a lifetime, the Eucharist was a more frequent event and, important to this discussion, it used natural substances which could be employed in healing. Benedicta Ward says that three kinds of miracles were connected with it: it could be seen as a theological miracle in itself; it could be accompanied by visions at the moment of consecration (a view of the consecrated host, it was believed, might protect from harm (Kieckhefer, 1989, 79); it could act as a “relic” of considerable power (Ward, 1982, 13-16). Healing could result simply from pious adoration or reception or from the use of the host or the sacred vessels as miracle-working relics. It is easy to see how the host could be used in magical rituals. The Fourth Lateran Council in 1215 expressly forbade people from carrying the consecrated host out of the church (for example, one might receive, but not swallow the host) as the Church’s official position was that the Eucharistic elements were part of a personal, spiritual miracle, not a display of magic power (Ward, 17-18).

As a rite of sacrifice (The Sacrifice of the Mass), the ritual of the Eucharist repeats in present time an event of the past (the Last Supper and the death and Resurrection of Jesus) which is both a sacrificial act in which the believing community completes the sufferings of

Christ and a rite of unification which the believing community hopes will heal. As Jolly says, "in the early medieval Christian worldview...physical and spiritual medicine functioned in harmony":

The most potent liturgical combination of act and words...was the recitation of the whole mass, in which the verbal power of the priest ordained by the holy church opened a doorway through the natural elements to heavenly power. Masses said over the herbs in a remedy called down God's blessing on his natural creations (the bread and wine for spiritual cure or the herb for physical cure) and served to drive out evil forces ... just as a mass of exorcism did (Jolly, 1996, 122).

Beyond the twelfth century, the rituals exhibit the same continuity. Duffy points out that in the High Middle Ages, *Horae* (prayer books used by the educated laity), mixed normal Christian prayers with those we might call superstitious (see Duffy, 1992, chapter 8). The letter of Charlemagne,³⁴ supposedly of angelic provenance, was popular among the educated. To distinguish the elite from the folk is, in this period as in most others, to confuse the issue. Even today, the practice of taking holy water from the church font or, in Latin American cultures and parishes, asking the priest to bless table salt for protective or healing purposes, is continuous with ancient practices and practiced by the educated.

Practitioners

The Church was always careful to preserve its monopoly on healing. Before the twelfth century, when university-trained doctors became more common, ecclesiastics liked to think that healing through saints was superior to medical healing. The medieval leech was a scientific opposition to both Christian and pagan healing. In the early Middle Ages he was seen by Christian leaders as having limited importance. These early physicians also

³⁴The letter of Charlemagne is variously described as having been given to Charlemagne by an angel or sent to him by the Pope. This charm purported to protect against all sorts of dangers, such as pestilence and fire. It was also used in the fifteenth and sixteenth centuries, written out and laid upon the abdomens of women in labour (Duffy, 1992, 273).

opposed the magical cures condemned by the Church. But they themselves competed with the curative power of the Church's sacramental system. Medieval hagiography abounds in examples demonstrating the superior power of the saints over the power of the leech. The leech, if his cures were more effective, could call into question the Church's own miraculous saints and healing shrines. Successful leeches could also rob religious orders of the revenue these shrines brought in (see Thomas, 1971, Kieckhefer, 1989, Siraisi, 1990, Flint, 1991). Alternative healing practices, Christian or pagan, offered comfort when the doctor was unavailable or too expensive. A medieval painting illustrates the competitive element vividly. In the first scene, the physician throws up his hands in a "what can you do?" gesture. He has failed to heal. In the second scene, the moribund patient leaps up at the benediction of a person with a halo (in Tambiah, 1990, plate 2.3, 35).

In Medieval Europe, physicians, monks, parish priests, midwives, diviners and folk healers, as well as those with no training whatsoever, practiced healing and learned from or competed with one another. Medicine was a learned profession in the classical tradition and these classical writings (Galen for example) were available to monks in the Middle Ages. In this period little distinction was made between physicians and lay healers. Monks studied medicine and some were sought out by royalty. Diocesan clergy were also encouraged to have medical education and rural priests used a variety of healing rites. Kieckhefer believes that some of the practices of rural priests, such as field-blessing ceremonies, were closer to magic than to medicine. In the twelfth century, not only were university-trained physicians becoming common, but Islamic writings on medicine were imported into Europe. However, professional training did not mean the end of techniques normally associated with vernacular or popular healing. As classical writings were the core of the medical curriculum, distinctions that twenty-first century people would make between magic and medicine were not evident (Kieckhefer, 1989, 57-58).

The twelfth century was a turning point after which official healers began to challenge the right of the lay-healers to practice. In the fourteenth century, the popes supported physicians' attempts to suppress the uneducated healer. An act of parliament in fifteenth century England tried to insist that all who practiced medicine have a university education. This act also attempted to exclude women from practice. Similar attempts were made in the sixteenth century. In the later Middle Ages, midwives were professionally licenced. In this period we see medicine attempting to reinforce legal control. Church and state often joined hands to suppress midwives. The *Malleus Maleficarum* was suspicious of the demonic activities of midwives. Midwives were required to take an oath renouncing the use of charms and other supposedly demonic routes to health and safe childbirth. By the fourteenth and fifteenth centuries, the rise of literacy led to self-help manuals. Thus people could learn how to let their own blood and examine their own urine without turning to physicians. Manuals containing charms and instructions for medical divination became common and available in vernacular languages (Siraisi, 1990; Kiekhefer, 1989; Thomas, 1971; Kramer and Sprenger, 1484, Rev. Montague Summers, trans, 1928, 1948; Duffy, 1992).

The Renaissance -- Dominant Trends, Events, Ideas and People

Among the trends and ideas were a renewed interest in antiquity, among events, the discovery and re-discovery of new drugs, the founding of the Royal College of Physicians, the continuation of folk healing and the advent of self-help medical pamphlets. An important figure who continues to influence complementary and alternative medicine was Paracelsus.

Returning to antiquity as an original source

The Renaissance was a period of intellectual ferment and reform. Just as Luther returned to the sources of Christianity -- the Bible -- so too did the medical humanists. They spurned

the Arabic and Medieval Latin translations of ancient Greek texts and created new translations, exposing, in Porter's words, "inept scholarship". In 1525, Galen's complete works were published in Greek with a new Latin translation. The retrieval of the original Greek texts promoted the view that the medicine of the ancients was the "true one". The scholars guarded these texts, interpreted them but also made innovations. In this period, new ideas about the causes of disease and its cure, were proposed. This was necessary as new diseases such as syphilis had appeared in England (Porter, 1997a, 167-172).

New drugs

Pharmacy changed in this period. Classical drugs were re-discovered and new products discovered in the Americas and Indies. Jean Fernel (1497-1558) of the Paris Medical Faculty believed some substances to fall outside the Galenic structure (Porter, 1997a, 173-174) and he reformed Galenic medicine. Galenic medicine, in spite of the scholars who debated it, was rarely challenged until Paracelsus launched his attack. In this period Felix Platter (1536-1614), the dean of the medical faculty at the University of Basel, wrote extensively on psychiatric disorders in *Praxis Medica* (1602). He "downplayed diabolical agency" in mental disturbance but advised amulets for madness (Porter, 1997a, 196). This was not inconsistent in the Renaissance but reveals a continuity (amulets) in the midst of a discontinuity (the rejection of diabolical agency).

Founding of the Royal College of Physicians

In 1518, Henry VIII chartered the College of Physicians, licencing and monitoring medical practice in London. After the reign of Charles II it became the Royal College. When Henry VIII dissolved the monasteries, hospitals that had been used to shelter the frail and feeble were closed. Some were re-established later as secular institutions: St. Bartholemew's, St. Thomas's and Bethlem Hospital (for the mentally ill) -- all in the city of London (Porter,

1997a, 198). The Royal College still oversees the profession of medicine in England and the Commonwealth and all physician-members may append FRCP (Fellow of the Royal College of Physicians) to their names.

The Continuation of Folk Healing

In spite of the existence of the Royal College and greater medical sophistication, the poor still went to cunningfolk and used herbal remedies even though parliament denounced this practice in the early sixteenth century. Unorthodox healing was resorted to by the elites as well as the so-called common people. One reason must have been the draconian techniques of the Galenic medicine of the day. Charms were still used. After all, in Thomas' words, a prayer was "always appropriate". Since even Protestants said that one should not rely on natural remedies alone, but accompany them with a prayer, it could be difficult to distinguish between charms and intercessory prayers. Thomas says that if people's consciences bothered them, they could always consult the church, the law or the medical profession to see if their healing method was orthodox (Thomas, 1971, 227 and see 318).

During this period, certain intellectuals looked with favour on the practices of the "folk". Paracelsus claimed that the knowledge of the woodsman or herbalist was worth more than all the medical knowledge of Aristotle and Galen (see Porter, 1997a, 201-205). We can see here the tendency of the elites, at certain periods of history, to plunder the lore of the village practitioner and romanticize the "natural".

Self-help medicine

A number of popular health-advice pamphlets became available to the literate public. One told its readers how to organize their homes and what dietary and exercise regime to follow. Others recommended temperance and work to enhance longevity. Texts on midwifery began

to appear. According to Porter, these booklets mitigated to some extent the gaps in the provision of institutional medical care in England (Porter, 1997a, 198-200).

Paracelsus -- the “father” of alternative medicine

Foremost among the figures of the New Learning in the Renaissance was Paracelsus (Theophrastus Philippus Aureolus Bombastus von Hohenheim, c.1493-1542). Roy Porter describes him as “a medical protestant if ever there was one” even though he was Catholic. Paracelsus studied medicine briefly but then became a wandering student. He believed that “the people” held wisdom and lore which all wise men should study. He came to believe that invisible powers interceded between God and man in a universe redolent of meaning, ideas he derived from the occultist Trithemius (1462-1516 CE) (Porter, 1997a, 201).

Paracelsus took an off-beat approach to the study of medicine. He rejected the teachings of Galen, that had canonical status in the medical schools of the time, and came up with medical explanations that combined mysticism and the esoteric with science. He emphasized the importance of particular bodily organs to health and rejected the conventional belief in the four humours. He believed that disease invaded from the outside. Paradoxically, while championing the cause of the “folk” and their remedies, he also put forward new ideas about chemistry, although he divided chemical substances (such as sulphur or mercury) according to their hidden and esoteric elements rather than their material properties. He thus stands at the intersection of three types of medicine: folk healing; esoteric medicine and scientific medicine. He is seen as the patron saint of alternative medicine (Porter, 1997a, 202-204).

Paracelsus held that “nature was sovereign, and the healer’s prime duty was to know and obey her” (Porter, 1997a, 202). This was quite different to the belief held by the scientific

philosopher Francis Bacon that the goal of science was to conquer nature. Bacon (1561-1626) saw science as “a tool for plundering, rather than a means of revering, nature” (Jecker, 1991, 6). Speaking of human nature, Bacon said that one should “bend nature as a wand to a contrary extreme, whereby to set it right” (Bacon, 1625, 212). In contrast, Paracelsus’ view was that the proud would be unable to read nature’s text; only “pious adepts” could see with eyes of understanding. The doctrine of signatures, while very ancient, was vigorously promoted by Paracelsus. This doctrine holds that God has given humans cures for all ills and written their purpose in the design of the plants. Hence orchids, which look like testicles, supposedly cure venereal disease. Porter sees Paracelsus “as perhaps influenced by radical Protestantism and in its faith in a priesthood of all believers: truth was to be found not in musty folios but in the fields, and in one’s heart” (Porter, 202).

Porter refers to the Paracelsian movement as a “heresy” which created serious divisions in medicine (almost as deep as the religious divisions of the time): English kings and queens sometimes supported unlicensed practitioners in contravention of the dictates of the College of Physicians³⁵; the French court sheltered Montpellier-trained Paracelsan doctors because the Parisian faculty of medicine did not accept their theories. From that point on, the medical profession tended to break into factions. The chief advantages held by Paracelsan medicine in this era was that it was completely Christian (Galen was seen to be heathen) -- important in the Reformation era. Paracelsus viewed medicine as a divinely granted gift and “charitable vocation” which “appealed to the people against the powerful”. In some places, medical care became an act of philanthropy. Physicians such as Théophraste Renaudot (1584-1653) gave free medical treatment to the poor. Renaudot even created a

³⁵To this day, the British royal family patronizes homeopathy which may well be the reason that its practitioners and hospitals are covered under the National Insurance Plan.

system that let the ill who lived too far away to travel to be diagnosed by mail. He designed a booklet with lists of symptoms and diagrams of the body. All patients had to do was tick the symptoms or mark “where it hurt” on the drawing of the body and mail it back to Dr. Renaudot. Much to the annoyance of the Paris medical faculty, Renaudot’s bureau received permission to create laboratories under royal sanction. They could do nothing as Renaudot was protected by Cardinal Richelieu (Porter, 1997a, 209).

Paracelsus was still an important figure in the seventeenth century and he continued to be published and read in the Enlightenment era. His work:

became firmly linked with the universalist tradition of the later seventeenth century, in which continuing motivation was provided by the idea of bringing all people, all languages and all religions into perfect harmony. It was probably this universalist association which prompted Newton’s interest in Paracelsus and other alchemical writings. Thus, as well as making an ineradicable medical contribution, Paracelsus remained a general intellectual force in certain circles (Webster, 1988, 81).

Seventeenth Century -- Dominant Trends, Events, Ideas and People

Among the dominant trends was a growing anti-authoritarianism, health-care reform and an increase in the number and type of pamphlets written to help individuals look after their own health without recourse to physicians. The most important idea, of course, was the elevation of reason in the period called the Enlightenment. René Descartes was the most influential figure in this period and his philosophy, along with Newton’s science, was responsible for the increasing mechanistic approach to medicine.

Anti-authoritarianism

The seventeenth century was an era of protest. England had suffered a civil war in which Cromwell’s party attempted to overthrow the monarchy. The monarchy remains but belief

in the power of authority was greatly diminished in this era. This period saw the growth of a sixteenth-century phenomenon -- health advice written for lay people (see Porter, 1997a, 198-200, 283), many of whom had no access to scientifically trained physicians. For the same reason, religious healers continued to practice. In Catholic countries, health care included the use of holy water from sacred wells, visits to shrines, the application of saints' relics and pilgrimages. Even in Protestant countries, certain beliefs endured: the seventh son of a seventh son had healing powers; Bourbon and Stuart kings could cure scrofula (the King's evil, cured by the King's touch). The practice died out in England in 1714 but the Bourbon restoration of 1815 revived the practice to strengthen its power. The last king to heal with his touch was Charles X on May 31, 1825. Other practices included relying on the curative properties of an executed man's hand or even the rope that hanged him (Thomas, 1971, 227-271; Porter, 1997a, 281-282).

Health-care reform

Attitudes to health care reflected the new anti-authoritarianism. Nicholas Culpeper (1616-1654) did not graduate from university but was an apprentice apothecary before he served poor Londoners as a doctor. His *Physicall Directory, or a Translation of the London Dispensatory* (1649) was a translation, certainly not authorized, of the College of Physicians' Latin *Pharmacopoeia*. Culpeper objected to the monopoly of the College of Physicians as "unchristian" because he believed that control of medicine by the College made medical treatment too expensive for the poor. Culpeper therefore wrote his own handbook in English, offering recipes for herbal cures (Porter, 1997a, 210). The College raged:

By two yeeres drunken labour he hath Gallimawfred the apothecaries book into nonsense...and to supply his drunkenness and leachery with a thirty shilling reward endeavoured to bring into obloquy the famous societies of apothecaries and chyrurgeons (in Porter, 1997a, 210).

Culpeper created an even “more controversial version”, *The English Physician Enlarged* (1653), which became known as Culpeper’s Herbal, a book which has been revised many times and is still in print. This work originally attacked all who exercised tyranny: priests, physicians, those who used Latin to create a monopoly of greed (physicians use of Latin kept knowledge from the common person). From this time on, most English medical texts were written in English. However, other attempts to destroy the College of Physicians and create state-funded health care came to nothing. Porter says that Galenic and Paracelsan medicine declined by the mid- to late seventeenth century. Paracelsan medicine simply joined other experimental scientific inquiries, considered to be part of the “new philosophy” and conducted by such organizations as the Royal Society. This Royal Society was chartered by Charles II, a patron of this new philosophy (Porter 1997a, 210-211 and see Culpeper’s original *Epistle to the Reader*, v - viii and *Letter to His Recent Consort*, ix-x, Culpeper, 1995 edition).

The elevation of reason in the Enlightenment

The universalist tradition, along with the elevation of reason and observational science as the only reliable source of knowledge, is central to the Enlightenment. A simplified understanding of this period holds that all that appeared non-rational -- scripture and revelation for example -- was rejected (Hanegraaff, 1998, 412) and that Enlightenment thinkers viewed the “mystical” or “occult” as utterly “*incompatible* with the values of the Enlightenment” (Hanegraaff, 411). This legacy is vilified in popular alternative healing literature as the enemy of the natural, the intuitive, the holistic. Wouter J. Hanegraaf, analyzing Isaiah Berlin’s article *The Counter-Enlightenment*, sees this as a view that needs to be refined (Hanegraaff, 1998, 411).

Enlightenment thinkers grounded their beliefs in the doctrine of natural law, believing that

human beings and certain principles are eternal and applicable in all times and places. In this view, cultural variations are irrelevant. Humans were considered to be a species alongside plants and animals; they were subject to universal laws that replaced the chaos of ignorance and superstition (Berlin, 1979, 1). However, though some eighteenth century philosophers rejected belief in divinity, most people of this era, including the intellectuals, were not atheists. Berlin says that the eternal principles of natural law governed “theists, deists and atheists”. Even when “thinkers might differ about what these laws were, or how to discover them, or who were qualified to expound them; that these laws were real, and could be known, whether with certainty, or only probability, remained the central dogma of the entire Enlightenment” (Berlin, 3-4).

The Eighteenth Century --Trends, Events, Ideas, People

Among the important trends were increased literacy, increased secularization, the influence of non-physicians on the evolution of medicine, the rise of medical competition and medical advertising. The most significant figures who influenced complementary and alternative medicine were Emmanuel Swedenborg and Anton Mesmer. Though Mesmer developed his theories in the eighteenth century, his influence was particularly marked in nineteenth-century America.

Public literacy

One cannot underestimate the power of greater public literacy. By the eighteenth century, printed books were affordable and medical handbooks for the general public became popular. One of the most popular was Methodism’s founder John Wesley’s *Primitive Physick* (1747). Wesley offered recipes that could be cooked up in any kitchen with readily available ingredients, like an infusion of valerian root for nervousness (still a popular remedy) (Wesley, 1747/1960, 90) or toasted cheese to place on a deep cut (Wesley, 62). He

also cited Dr. Sydenham's recommendation that obstruction of the bowel could be eased by holding up to one's abdomen a live puppy (Wesley, 83). Family books reveal many recipes for healing unguents of occult provenance: dead toads, viper's blood. Many people continued to go to folk healers, trusting the "experienced old woman" over "the learnedst but unexperienced physician" (Thomas Hobbes in Porter, 1997a, 283). In the late eighteenth and early nineteenth centuries, according to Robert Southey, cunningmen and women still plied their trades near every town in England. Physician William Buchan, (1769) wrote a self-help manual, *Domestic Medicine*, with the revolutionary aim of returning medicine to the people (Porter, 1997a, 282-283).

Medicine for the people is a recurring theme in the history of medicine. The current interest in alternative medicine is said to be the appropriation of health care by laypeople. Buchan's message was that medical democracy was "a fulfilment of the rights of man declared by the French revolution" (Porter, 1997a, 283). Porter sees these manuals as functioning in two directions: written by doctors, they maintain medical authority; written to help people be their own physicians, they bred the "health Protestantism" which encouraged the alternative medicine of the following century (Porter, 283-284). The same could be said of the current interest of conventional medicine in incorporating alternatives into its practice: it maintains medical power but it recognizes medicines outside the control of physicians.

Secularization and the waning of the supernatural

The ideas that originated in the Enlightenment slowly pervaded popular thought and spread to the new world. As people felt able to control their own lives, Gottschalk says, "faith in orthodox supernaturalism waned." As hope for human progress and a heaven on earth increased, heaven and the supernatural seemed further away (Gottschalk, 1973, 9- 10). The forces of secularization were already present in nineteenth and early twentieth century

American society. Gottschalk points to the rise of liberal Protestantism which denied miracles (Gottschalk, 20-22). Weber says, in *The Protestant Sects and the Spirit of Capitalism*, that at the time of his observations, membership in a Protestant sect often served more as a letter of credit or character reference than as a token of strong spiritual impulses. He noted that this use of sect membership was disintegrating with secularization (Weber, 1906, 305-313).

Lay influence on the evolution of medicine

Roy Porter describes eighteenth century English medicine as one in which laypeople had a decided influence on the way in which different types of medicine evolved. The sick of Georgian England could turn to licenced physicians; traditional “irregular” practitioners such as empirics; wise-women and the retailer of nostrums, who offered medicine as merchandise. In this period, using terms such as professional and alternative medicine is, according to Porter, anachronistic. In eighteenth century England, medicine was: (1) not very effective; (2) characterized by “low professionalisation (or high pluralism”); (3) was notable for its lay involvement and emphasis on consumer choice and was (4) an increasingly important item of commerce (Porter, 1988, 3).

Medical “quackery” and medical competition

The eighteenth-century was the era of medical “Quackery”³⁶(Porter, 1988, 2-3). While it is true that physicians who were fellows of the Royal College of Physicians enjoyed a prestige not granted to those who hawked patent medicines, many medical entrepreneurs were rich and well-regarded by their fashionable clients (Porter, 1988, 2). Moreover, conventional physicians and “quacks” interacted freely. Conventional physicians might

³⁶Porter uses this term “in line with Samuel Johnson’s ‘one who proclaims his own medical abilities in public places’” (Porter, 1988, 3).

prescribe commercial powders or tonics, ubiquitous in the eighteenth century. Sally Mapp the bone-setter was welcomed into high society and even asked by the President of the Royal College of Physicians to treat a member of his family. A panel that included society's most important surgeons "recommended that Parliament should fork out £5000 to buy the secret formula of Mrs Joanna Stephens' stone-dissolving remedies..." (Porter, 1988, 7).

Because medicine was not effective in curing disease, people who could afford it tried whatever was on offer. Given the draconian nature of orthodox medical cures (bleeding, vomiting and the administration of powerful purgatives) (Porter, 1988, 4), alternatives were attractive. Hahnemann's gentle homeopathic medicine found a ready market in this century.

While chartered medical corporations could enforce their power where they had jurisdiction, this power was limited throughout the eighteenth century. While some historians speak of the Royal College exercising its privileges and launching suits against unlicensed practitioners, Porter says that the powers of English medical licencing bodies did not extend beyond London and only a few local towns had medical guilds with the power to licence and enforce. Moreover, unlike the French and German bureaucracies of the time, in London, The College of Physicians did not police the practices of empirics or other irregular practitioners. The founder of Mesmerism, Anton Mesmer, who had been run out of Vienna and Paris, practiced freely in London (Porter, 1988, 5-6).

Medical advertising

Lay people had an important influence on eighteenth century medicine. Porter discusses Nicholas Jewson's suggestion that patients were so powerful that they encouraged regular medicine to give birth to the competing medical systems such as homeopathy, that became the alternative medicine of the following century (Jewson, 1976, 1974 in Porter, 1988, 7-8).

It was a buyers' market. When the public have a voice in the way medicine is practiced, Porter says, distinctions between conventional and unconventional medicine become less important. However, orthodox physicians worried about the "ignorant laity [who] were easy prey to nostrum-mongering sharks" (Porter, 1988, 8- 9), a situation not unlike today's in which bodies like the National Council Against Health Fraud (also known as the National Council for Reliable Health Information) actively campaign against alternative medicine.

Health cures abounded in the eighteenth century. In early modern England, Porter says, medical treatment took the form of ingesting drugs. Regular physicians therefore led people to turn to a pill or potion when seeking cure. Commercial medicines, some of which are used today, included Dr. James's Powders and Fryar's Balsam (Porter, 1988, 10) . Most of these remedies were proprietary medicines but some were patented, which gave the manufacturer a monopoly and official approval. Before the seventeenth century, peddlars of such nostrums would have marketed them on the street. By the eighteenth century, written publicity became widespread (along with the rise of literacy) and a larger middle class had more income to indulge their desire to test out the extravagant claims of medical merchants. Handbills posted in coffee houses would claim that remedies would infallibly prevent the plague (Porter, 1988, 10-12). The sophistication of the advertising has increased, but modern elixirs make similarly extravagant promises.

The "irregular medicine" of the eighteenth century laid the groundwork for medicine as a commercial practice (Porter, 1988, 19) which developed more fully in the nineteenth century. Whereas eighteenth century purveyors of patent and proprietary medicines were at pains to give their remedies fashionable or respectable names, sometimes naming them after famous conventional doctors, nineteenth century irregulars spurned such elitist claims and "advocated going 'back to Nature'" (Porter, 1988, 13-14).

Swedenborgianism

Mesmerism, to be discussed in the section discussing the nineteenth century, was, according to Robert Fuller, unofficially connected to a European metaphysical movement, Swedenborgianism. Emanuel Swedenborg's (1688-1771) teachings appealed to the gnostic instincts of those looking for a spirituality beyond the ordinary. He proposed that individuals could learn truth not from scripture but through direct illumination. In contrast to Calvin's belief that human nature was essentially sinful, Swedenborg believed in the capacity of the soul to develop without limits (see Fuller, 1989, 49- 50). These opposing views of the nature of human beings have been found throughout the history of Western Christianity with Augustine, Luther and Calvin representing the pessimistic emphasis, and Origen and Erasmus championing the cause of the human being as originally blessed and originally good.

Swedenborg was considered to be a reputable scientist until Immanuel Kant exposed him as a clairvoyant. It was only after he suffered a spiritual crisis in his mid-fifties that he began to write of his "experiences with spirits and angels" (Hanegraaff, 1998, 424).

Swedenborg believed that individuals are so made that they can receive "psychic influx" from higher planes with the aim of achieving harmony between the heavenly and the earthly planes. Regeneration is achieved through harmony, not repentance, Fuller says, a belief also popular in twentieth and twenty-first century New Age thought. In Swedenborg's philosophy, God is approached as a being who can infuse the individual with power and knowledge rather than as an authority to be propitiated and petitioned with sacrifice and prayer (Fuller, 1989, 51). The Church of the New Jerusalem was founded after he died to preserve his teaching. Swedenborg's ideas influenced the spiritualists of the nineteenth and

twentieth centuries.

The Nineteenth Century -- Trends, Events, Ideas and People

The nineteenth century is notable for the founding of new religious denominations devoted to healing, such as Christian Science, for a rejection of Protestant orthodoxy and a return to nature and for a flourishing interest in metaphysical healing movements and in spiritualism.³⁷ Many of these trends and movements reflected a utopian faith in the infinite perfectibility and progress of individuals and society. Important figures to complementary and alternative medicine were Anton Mesmer, Phineus Parkhurst Quimby and Mme Helena Blavatsky, the founder of Theosophy (who will be discussed in the next chapter).

New healing movements and denominations

According to Roy Porter, the nineteenth century stands out as the century that rejected orthodox medicine on principle and created new healing movements and philosophies. He describes these healing movements as “mirroring the myriad religious dissenting sects and socio-political groups which gained a following in an era of mass literacy and grassroots discontent... .” What all healing sects had in common, whether they were presented as a form of science, the result of prophetic inspiration, or a new religion, was a tendency “to denounce modern lifestyles as unnatural and ... [to accuse] regular medicine of being an oligarchic closed shop... .” They emphasized self-help, simple living, seeking healing in nature (Porter, 1997a, 390, 389), a focus with present-day reverberations.

³⁷Although this section will not discuss spiritualism, it was hugely popular in the nineteenth century and seances came to be like parlour games. Many spiritualists were exposed as charlatans but spiritualism did not disappear. Modern versions of spiritualism include channeling extra-terrestrial entities as well as the spirits of the departed.

Rejection of Protestant orthodoxy and a return to nature

Nineteenth century American authors with a deep religious sensibility rejected Protestant orthodoxy, according to Stephen Gottschalk. In his view, Melville, Emerson, Thoreau, Whitman and Hawthorne were, in a sense, prophets of a new religious consciousness in America. At the same time, religious revivalism dominated the American landscape and, as a counterpoint to the rejection of the static symbols of Protestant orthodoxy, revivalist preachers attempted to increase their emotional appeal (Gottschalk, 1973, 10-11).

A notable feature of New Age religion and holistic healing is what Fuller calls “cosmic optimism”³⁸ which was and is a feature of the “positive thinking” found in metaphysical and New Age movements (Fuller, 1986, 22-27 and see Hanegraaff, 1998, 467). According to Frederick Conner, Emersonian Transcendentalism brought Platonic ideas to a nineteenth century American public. His “evolutionism” had little to do with the science of the day. Emerson was no Darwinian. He also saw science as a “half-knowledge” (Conner, 1949, 58-59, in Hanegraaff, 468). This is romantic evolutionism which greatly influenced metaphysical movements (Hanegraaff, 469). Historian of religion Philip Jenkins notes that Emerson’s Transcendental movement was also responsible for bringing Hindu ideas to America (Jenkins, 2000, 71).

Robert C. Fuller says that:

...American psychologies of the unconscious mind represent structural replays of indigenous American religious and cultural traditions. The “American” unconscious has displayed an enduring tendency to symbolize harmony, restoration, and revitalization. In sharp contrast to those European psychologists who saw in the unconscious a symbol of rift, alienation, and inner division, Americans have imbued the unconscious with the function of restoring harmony between the

³⁸This phrase is part of the title of a book by Frederick Conner, *Cosmic optimism: A study of the interpretation of evolution by American Poets from Emerson to Robinson*, published in 1949.

individual and an immanent spiritual power (Fuller, 1986, 5-6).

Henry James united psychology and religion which Hanegraaff describes as a distinctly American tendency. Hanegraaff links nineteenth century New Thought with the mid-twentieth-century Human Potential Movement (Hanegraaff, 1998, 490). This popular religious approach is called “Harmonial Religion”, a term coined by Sydney Ahlstrom (Ahlstrom, 1972). Harmonial religion united body, mind, spirit and prosperity. If one is “in tune with the infinite” all will be well (Ahlstrom, 1972). Though Hanegraaff sees harmonial religion’s understanding of “the cosmos” as a “psychologizing tendency” caused by the secular search for “scientific religion” (Hanegraaff, 1998, 495 and see Fuller, 1982, 49), the following statement suggests links between nineteenth century harmonial religion and the sixteenth century Neoplatonic doctrine of correspondences and the coinherence of all worlds.

[The] immanent divine ‘Mind’... is the source and foundation of finite minds. Health and harmony on the level of human existence is achieved by replicating in one’s own mind the harmonious perfection of the cosmic whole. Since the universe is flawless, the individual soul is flawless as well, it is only by *believing* otherwise (i.e., by creating an illusion of imperfection) that one disturbs the harmony and interrupts the continuity between the outer and the inner universe (Hanegraaff, 1998, 494- 495).

A discussion of these nineteenth century movements is important to understanding twentieth and twenty-first century healing movements, particularly those associated with New Age thought. J. Gordon Melton sees New Age thinking as a modern and altered version of occult and metaphysical religions that have existed for centuries, flourishing in the eighteenth-century Enlightenment under the guise of science and replacing medieval magic (Melton, 1988, 36). Hanegraaff says that Melton sees this development not as a “continuity but a *reinterpretation* of traditional tenets under the impact of modern developments” (Hanegraaff, 1998, 374).

Following is a discussion of two significant movements.

Nineteenth century metaphysical healing movements

The two nineteenth century movements which most influenced alternative healing in America were Mesmerism (which, as noted before, began in the eighteenth century) and Quimbyism.

The nineteenth century father of psychology, William James, saw these movements, to which he gave the name "Mind-cure", as evidence of people's healthy-minded ability to conquer doubt and fear with hope. Also called New Thought³⁹, Mind-cure was syncretistic, drawing its inspiration from the Gospels, the New England Transcendentalists, spiritism and Hinduism (James, 1902, 94-95). According to James, this movement led not only to physical cures but had an indirect influence on society as a whole: "One hears of the 'Gospel of Relaxation,' of the 'Don't Worry Movement,' of people who repeat to themselves 'Youth, health, vigor!' when dressing in the morning, as their motto for the day. Complaints of the weather are getting to be forbidden in many households; and more and more people are recognizing it to be bad form to speak of disagreeable sensations..." (James, 95). Modern-day versions of Mind-cure can be seen in the many optimistic books written for the genuinely ill and the worried well.

A severe critic of this way of thinking, M.D. Faber, sees it as an expression of, in

³⁹A student of Mary Baker Eddy, Emma Curtis Hopkins, founded what was later called New Thought. Various national conventions of this movement were held in the last 10 years of the nineteenth century and, in 1914, an International New Thought Alliance was created. By 1940, 18 New Thought churches and groups functioned. Among them were the Church of Advanced Thought and the Metaphysical School of Health. Some, particularly the Unity School, flourished through the use of mass marketing techniques. Like many other nineteenth century metaphysical movements, Unity School reflects American belief in personal independence, the desire for prosperity and the belief in limitless personal and societal progress (Jenkins, 2000, 54-56).

psychoanalytical terms, “infantile omnipotence” (Faber, 1996, 7). The New Thought movement taught people that it was one’s own mental attitude that led external events to exert power over the individual. If one did not believe in the power of an external influence, then it could not affect one (Hanegraaff, 1998, 489). The New Age belief that we create our own reality is, suggests Fuller, directly derived from New Thought (Fuller, 1982, 1446-147; Hanegraaff, 489). Some modern holistic healers believe that individuals are responsible for creating their own illness⁴⁰ (see Hanegraaff, 488-490).

William James, in *The Varieties of Religious Experience*, noted that metaphysical healing movements would play a role in popular religion. Mid-nineteenth century healing movements suited the “progressivist and perfectionist tendencies of early nineteenth-century American Protestantism” (Fuller, 1989, 9). They were very much a part of an important American belief -- that divine and natural law intends human happiness; that each person is responsible for his or her own physical salvation; that disease is not God’s punishment but subject to laws which humans can harness and apply. Thus individuals are as responsible for their own physical salvation as they are for their divine salvation (Fuller, 1989, 20-21). The popular healing movements of the nineteenth century are a fine example of popular Protestant belief -- a unique example of American pragmatism which led to a uniquely American philosophy in which “concrete therapeutics” were wedded to a “systematic philosophy of life” (William James, 1902, 96).

⁴⁰ The belief that one causes one’s illness is related to the Calvinist belief that one is responsible for the good and evil that befalls one. Personal prosperity is viewed as a sign that the person is one of the Elect.

Mesmerism

The science of animal magnetism was developed by Franz Anton Mesmer (1734-1815)⁴¹.

He believed that an invisible fluid, called animal magnetism, existed in matter and conducted light, heat and electricity between physical objects (Fuller, 1989, 38-39). Mesmerism is an important movement in any discussion of the connection between religion and complementary and alternative medicine. Its practitioners believed that people in a mesmeric trance were free of the five senses and thus open to receive a flow of animal magnetism. The reception of such a power led to healing but also to transcendent mystical states.

Mesmerism's adherents believed that people could learn to become independent of mesmerists and able to open themselves to receive the healing power of animal magnetism (Fuller, 1989, 43). Several alternative practitioners based their practice on Mesmer's ideas, for example, the founder of chiropractice, D.D. Palmer. Modern alternative movements influenced by Mesmer include all therapies that rely on the idea that invisible energies exist that can be balanced by a competent practitioner. Techniques, such as the way in which Therapeutic Touch practitioners pass their hands over (but not on) the body, also mimic mesmeric "passes".

Swedenborg had rejected, early in his scientific career, the idea of "*spiritus animales*",

⁴¹During Mesmer's career, a healer called Johann Joseph Gaßner claimed to heal by calling on the name of Jesus to cast out demons but the Church authorities, influenced, Hanegraaff says, by rationalism, were concerned. Mesmer was invited to Munich to intervene. He told the Cardinal that Gaßner's work was neither fraudulent nor supernatural but could be ascribed to the workings of nature. Gaßner, he said, cured diseases caused by bodily disharmony which "hindered the flow of the invisible fluid." In other words, Gaßner was guilty of using unscientific explanations for his miracles of healing. This led to an interesting outcome. Gaßner was no longer allowed to heal; Mesmer became a member of the Bavarian Academy of Sciences. Mesmer was seen by the Church of 1775 as a man of science whereas Gaßner was viewed as "superstitious". Later, however, according to Hanegraaff, Mesmer himself was rejected as a fraud by the scientific and medical establishment who could not decide whether his success was caused by natural or supernatural powers (Hanegraaff, 1998, 431- 432). Here we see echoes of the late medieval debates about acceptable and condemned magic.

organs that mediated between body and soul, as he did not want scientists to “deny the independent existence of the spiritual.” He would therefore hardly have accepted Mesmer’s belief in subtle invisible fluids. Hanegraaff says that “one can only try to imagine his reaction, had he known that mesmerism and his own teachings would eventually be presented as fully compatible by occultists during the course of the century which followed” (Hanegraaff, 1998, 430).

Mesmer himself rejected mystical explanations for invisible fluid but Hanegraaff sees his ideas as “largely rooted in esoteric traditions...” His fluid was an eighteenth-century version of the Aristotelian and Stoic beliefs in *pneuma* “and the Platonic *ochèma*” in which the medieval idea of natural, vital and animal spirits, and the neoplatonic belief in the “astral body” were grounded. Hanegraaff describes Mesmer’s theory as a modern type of “*magia naturalis*” (Hanegraaff, 1998, 433).

Mesmerism appealed to occultists and scientists. Invisible fluid could be seen to be spiritual but some scientists, such as the English physician John Elliotson, defended Mesmerism. Many saw it as an example of how science triumphs over nature (Hanegraaff, 1998, 434). Hanegraaff points to Mesmer’s contribution to these utopian ideas. If an invisible fluid was “the universal key to health and harmony... .scientists, physicians, psychologists, philosophers, or occultists could all adapt such a proposition to their own purposes and draw from it implications undreamt-of by its originator” (Viatte, 1927, 224-225 in Hanegraaff, 435). Mesmer had, unwittingly, fed the utopian dreams of a heaven on earth in which all divisions -- between body and spirit, between peoples, between religion and science, between God and his creation -- would be erased (Hanegraaff, 435).

These enthusiastic and utopian ideas are enduring as a comparison between the following

two claims, written many years apart, reveals:

While the entire globe seems to prepare itself, by a remarkable revolution in the movement of the seasons...natural science and philosophy make the greatest of efforts in order to spread and propagate everywhere their beneficial lights...Above all, the end of this century represents an historically highly interesting epoch, marked by a sudden, and almost general fermentation of the spirit. This fermentation is produced by two singular circumstances, the aerostatic experiences and animal magnetism.

Behold a general revolution ... Men of a new kind will inhabit the earth; they will make it more beautiful by their virtues and their works; they will not be held back by their careers, or by ailments; they will know of our evils only from history (J.L.Carra, *Examen Physique du Magnétisme*, and P. Hervier, *Lettre sur le magnétisme animal*, in Viatte, *Sources Occultes*, 1927, 1, 224, cited in Hanegraaff, 1998, 434).

Over sixty years later, the enthusiasm of a medical doctor is even more pronounced:

When individuals change, the whole planetary consciousness also evolves. As above, so below. The evolving patterns of individual human awareness can eventually produce larger changes in the global macrocosm. As increasing numbers of human beings begin to grow spiritually through the inner understanding of their illnesses and energy blockages, and as they begin to realize their true divine nature, they will also start to recognize that all people are subtly connected to each other and to the world around them. As the enlightened consciousness of this small segment of humanity grows, it will have a ripple effect upon the minds of the greater planetary whole. The rising tide of increased spiritual awareness will begin to affect larger numbers of people through a kind of cosmic resonance effect. When enough minds have changed to reach the critical threshold necessary to move the entire global consciousness to a new level of healing and awareness, we will have arrived at the New Age (Gerber, 1988, 467-468).

Optimism is evidently a durable instinct.

Mesmerism first became known to Americans in the late eighteenth century but it was the Frenchman Charles Poyen who made it popular. Calling himself a Professor of Animal Magnetism, Poyen conducted a lecture tour of New England in 1836. He quickly became famous as a healer (Fuller, 1982, 16-17; 20). People claimed he cured them by passing his hands over the affected part in an attempt to “direct the flow of animal magnetism.” A former Christian evangelist, Poyen claimed that when fully accepted, mesmerism would make the United States “the most perfect nation on earth” (Poyen, 1837 in Fuller, 1989,

41- 42), a belief that appears to have found fertile ground in a society which optimistically believed that society could become perfect through its citizens (Fuller, 42).

Mesmer's ideas influenced Freud and the development of psychoanalysis (see Fuller, 1982, 1986). One of Mesmer's students, the Marquis de Puysegur, discovered that patients subjected to Mesmer's technique sank into a hypnotic trance (becoming, literally, mesmerized) and were able to recall forgotten facts and experiences as well as acquire telepathic and clairvoyant capacities (Fuller, 1989, 39).

The theory of animal magnetism, called vital force in homeopathy, *chi* in Chinese medicine, as the force which unifies "matter, mind and spirit, (i.e., animal magnetism) in a single cosmological system", was radical and, as Fuller says, placed this causal theory outside both orthodox Protestantism and orthodox medicine. But people of the time spoke of conversions to Christianity due to the influence of the theory of animal magnetism, he adds. Thus alternative healing was viewed as a route to religious belief. Although it had no connection with institutional religion, Mesmerism, Fuller says, was seen as a variation of the religious revivals of what was called the Second Great Awakening (the term used by early nineteenth-century evangelical preachers to describe an evangelical fervour that transcended denominational boundaries). Just as revivalists had encouraged a form of " 'alleviated Calvinism'" in which sin was viewed as correctable failure rather than a result of "inherent depravity" so too was mesmeric healing viewed as a way of improving humanity according to Fuller. The stoic, classicist view of humans as subject to sin and suffering, which must be endured, was replaced by unbounded optimism in the human capacity for infinite perfectability. This era saw the birth of many new religious movements, particularly of the millenarian variety, that attempted to storm heaven and call down the Holy Spirit (Fuller, 1989, 44-48) in an attempt to bring men and women closer to the spiritual forces in the

universe.⁴²

Mesmerism encouraged people to challenge orthodox religion. It helped individuals to discover a cosmology which was both “religiously and scientifically satisfying” (Fuller, 1989, 49) without being specifically religious. It was, like all the other metaphysical movements of the nineteenth and twentieth centuries, a species of “unchurched religion”.

According to Fuller, Mesmerism, and its antecedent, Swedenborgianism, not only gave a metaphysical dimension to nineteenth century healing systems and their twentieth-century progeny; these movements also prepared the ground for the spiritualism which emerged “as a distinct tradition of unchurched American religiosity.” The early spiritualists imitated mesmeric healing techniques when they engaged in healing rituals. These two movements also influenced the founders of chiropractic and osteopathy. The “metaphors” and “techniques” of these seemingly physical/mechanical healing systems derive both from mesmerism and spiritualism (Fuller, 1989, 56- 57).

Quimbyism

One of the most successful healers in the nineteenth century was Phineas Parkhurst Quimby (1802-1866), whose way of understanding mesmerism inspired the New Thought movement. Quimby had been inspired by Charles Poyen’s demonstration of mesmerism to look into the theories of animal magnetism. He placed his student Lucius Burkmar in a mesmeric trance and directed him to use his clairvoyant abilities to diagnose illness and

⁴²Fuller notes that of the five American-born religious groups (Christian Science, Seventh Day Adventism, Mormonism, Jehovah’s Witness, Pentecostalism) two, Christian Science and Seventh Day Adventism, are explicitly linked to unorthodox healing and the other three have a strong belief in religious healing, although they, as well as the Seventh-Day Adventists, attribute healing to biblical, not metaphysical causes (Fuller, 1989, 61).

prescribe remedies. From time to time, Quimby worked without Burkmar's help, simply making mesmeric passes over his patients' heads to "recharge their batteries", so to speak. Quimby at first believed that all his healings were due to animal magnetism and that "fluid" was responsible. Quimby eventually questioned both the theory of animal magnetism as well as the clairvoyant powers possessed by his assistant (see Quimby, 1921, 52-53). According to Fuller, Quimby wondered if the source of healing was simply his assistant's rapport with patients that enabled him intuitively to grasp what the patients already believed to be the problem. If his assistants were able to confirm for patients what they already believed, then the innocuous remedies prescribed worked because they worked on the patients' beliefs. Quimby came to believe that illnesses were caused by beliefs: "All disease is in the mind or belief. ...to cure the disease is to correct the error... ." The patient's belief then became crucial to healing (Quimby, 1921, 186; Fuller, 1989, 58-59). This is the older version of New Age claim that we create our own reality.

Quimby's theories turned the " metaphysical categories of mesmerism and Swedenborgianism into a pragmatic philosophy..." (Fuller, 1989, 60). His teachings were disseminated by his students Julius and Anita Dresser and Warren Felt Evans who "were instrumental in developing Quimby's mind cure into a full-blown philosophy of 'positive thinking', which could be applied not only to the healing of illness but to routine affairs of everyday life as well" (Hanegraaff, 1998, 488). The following nineteenth -century book, inspired by these ideas, would not look out of place in a twenty-first century bookshelf: *Thought is Power; How to Get What You Want; Making Money: How to Grow Success* (Fuller, 1982, 146). Evans offered his readers ancient "secrets" he described as hidden from the common people. Among them was the practice of affirmations which Evans attributed to Jesus (Judah, 1967, 162, 167, in Hanegraaff, 488). The use of affirmations is a popular healing ritual in which the sufferer is instructed to make such statements as "my

tumour has shrunk”.

Quimby's ideas were promoted by his patients, one of whom was Mary Baker Eddy, the founder of Christian Science (Fuller, 1989, 60). Although Eddy was later to repudiate Quimby's influence on her doctrine, Gottschalk says that her work owes much to his ideas and, in the polemical literature on Christian Science, some claimed that she directly copied his work (see Gottschalk, 1973, 129-138). Later, however, Eddy came to view Quimbyism as a type of Mesmerism and viewed Mesmerism as dangerous (Gottschalk, 1973, 133-134). In later life, Eddy viewed Animal Magnetism as a type of demon possession and warned her followers to pray to be protected from it (Eddy, 1906, 100-106). The chief difference between Eddy's system and Quimby's is that Christian Science is a religion in which healing is only indirectly a goal whereas “Quimbyism was a healing method and only” indirectly a “religious teaching” (Gottschalk, 1973, 130).

The idea that illness is an error of the mind can be found in many popular books on self-healing. Twentieth and twenty-first century versions of this doctrine attribute illness to negative attitudes (the so-called “cancer personality”) often claiming that negative attitudes impair the immune system, leaving the individual vulnerable to illness. This belief in mind over matter can lead those who have succumbed to serious illness to feel that they are at fault. Thus guilt over sin has been transformed into guilt about pessimistic attitudes.

Fuller and Hanegraaff see in Quimby's work a psychological version of the Protestant ethic:⁴³

⁴³Fuller notes that Quimby's understanding of Mind Cure reinterpreted the Protestant link between religious belief and prosperity by “psychologizing” to substitute right thinking for religious belief (Fuller, 1982, 131).

... a doctrine which was peculiarly well-suited to a country raised in the Puritan tradition. His [Quimby's] doctrine implied that God 'sanctions men's acts according to their beliefs, and holds them responsible for their beliefs right or wrong without respect to persons' [Quimby, 1921, 327, as cited in Fuller, 1982, 131] ; and it confirmed that 'right belief' and material prosperity are intimately connected. At the same time, Quimby built a bridge between the romantic religiosity of Emersonian Transcendentalism and a worldview which is more properly referred to as occultism (Hanegraaff, 1998, 487).

Fuller says that Quimby translated "the rather vague metaphysical language of an Edwards [Jonathan Edwards was a transcendentalist] or Emerson into the semblance of an empirically-based science" -- a type of "reified" Transcendentalism (Fuller, 1986, 48, cited in Hanegraaff, 1998, 487). This pragmatic turn, Hanegraaff says, is akin to what Arthur Versluis saw as New Thought's "trivialization" of Transcendentalism (Hanegraaff, 1998, 487).

Continuities, Discontinuities and Disruptions

Discontinuities in the official world of church and state profoundly affect vernacular practice. Gregory the Great had, in the sixth century, encouraged the use of Christian healing charms as a substitute for pagan ones, and suggested that people should visit saints' tombs for healing instead of holy trees and wells (Flint, 1991, 76-77). These practices were popular right up to the fifteenth century and beyond. But whereas they were considered holy and pious in the tenth century, by the fifteenth their practice could lead to accusations of witchcraft.⁴⁴

⁴⁴The *Malleus Maleficarum*, written by two Dominican inquisitors in the late fifteenth century as a guide to witch trials, pays particular attention to healing charms. In fairness to its authors, Krämer and Sprenger, their work did point out that women might use remedies which could not be explained by the science of the day and these remedies need not be assumed to work because of the power of demons. Works of healing could be performed by the good influence of heavenly bodies and need not be aligned with evil power. This is a balanced view in a work that otherwise ascribes to women the most appalling powers (causing impotence, depriving men of their genitals). In spite of its extreme misogyny and fantastical beliefs from a twenty-first century standpoint, the *Malleus* was written to ensure that victims of the Inquisition received a fair trial. While this might

What are we to make of this? It would seem that not only in the tenth and eleventh centuries, but even in the sixteenth, the use of Christian prayers and sacramentals in what we would see as a magical application was considered by the church to be acceptable. As Duffy points out, charms listed in the *Horae* of the high Middle Ages were part of a Catholic cosmos of shared belief in the miraculous power of God (Duffy, 1992, 279 and see 266-287). While the learned at this late date (or even in the fifteenth century Inquisitions) might make careful distinctions between what was acceptable and what magical, it is doubtful if the average person engaged in such hair-splitting.

During the early and high Middle Ages, the relationship between the official church (and churches, after the Reformations) and vernacular healing practices underwent innumerable changes. The period began with the Catholic Church dominant in Western Europe and concluded with the significant changes wrought by the several Protestant and then Catholic Reformations (commonly referred to as the Counter-Reformation).

The sixteenth century division of magic as manipulation and prayer as supplication is not much help in understanding these practices before this period and may not be of much help now. The person praying may not have thought she was coercing God but simply showing piety, reverence and trust in a ritual that had the sanction of Church and community. Those who use healing rituals hope that they will work. Coercion and supplication undoubtedly were mixed. Christians then, as now, may not have subjected their pious practices to intense scrutiny. Scrupulous self-examination only became common with the encouragement of

seem akin to offering physicians advice on how to torture humanely, its importance lies in its contribution to the evolution of Western law and its emphasis on fairness to the accused (see Krämer and Sprenger, 1486, Rev Montague Summers, Trans., 1928, 1948).

Calvinist reformers who demanded that the ill trust in God's providence alone and examine themselves for any failure in trust. But even Puritans could engage in practices their official doctrine considered magical as David Hall makes clear in *Words of wonder; days of judgment* (1990).

In spite of enormous change, these centuries demonstrate continuities in terms of the enduring quality of vernacular healing beliefs, as well as discontinuities in the way in which the official church and law (both very closely aligned) viewed them. For example, what was considered the science of the day (natural magic in thirteenth century terms) became superstitious practice or even witchcraft in the fifteenth century Inquisition, and what had been condemned by Augustine as the work of demons (for example, the soothsaying aspects of astrology) became a respectable intellectual pursuit in the sixteenth century Neoplatonic movement.

The Christian Church had encouraged the substitution of Christian ritual for pagan. The beginning of John's Gospel, *In principio erat verbum*, that was recited at the end of the Tridentine Mass, the official Eucharistic ritual before Vatican II, was recommended in the *Lacnunga* against enchantment, one cause of physical illness. This gospel was laid by John of Salisbury in the twelfth century on sick patients.⁴⁵ By the sixteenth century, a woman was accused by a physician of bewitching a sick child by reading this very gospel (Flint, 1991, 316-317). The encouraged practices of earlier centuries became the suspected practices of the sixteenth and seventeenth centuries and the use of prayer charms, once acceptable, were suggestive of witchcraft (Thomas, 1971, 304).

⁴⁵Flint says that the importance of these verses probably had an effect on their inclusion in the order of the Mass as the "last Gospel" (Flint, 1991, 317).

The Inquisition refined the definitions and distinctions between magical, demonic superstition and natural healing. At this point, practices that would probably have been unquestioned moved underground. Who would want to be suspected of witchcraft? In terms of the relationship of the official church to these practices after the first inquisition, we see a tension between the official church in Rome and the local clergy. Just as, many centuries earlier, Rome had pleaded with those in the mission fields to adhere to orthodoxy in magical matters, the missionaries argued that official doctrine had to be adapted to local conditions (an argument still current in the Catholic Church). Many village clergy of the time were undoubtedly practicing healing themselves, or at least protecting their parishioners who did. We must not underestimate the importance of the *Malleus Maleficarum* in defining for centuries beyond its writing the distinction between demonic magical healing as opposed to true Christian healing. The *Malleus* was used as a law manual in later witchcraft trials and reified concepts drawn from what had simply been practices without discourse.

In the sixteenth and seventeenth centuries, sharper distinctions were made between religion, magic and science. Even in the vastly changed world of the seventeenth century, healing charms and rituals were used not only by cunningfolk but sometimes by the learned (Thomas, 1971, 328). One notes that even in the twenty-first century Catholics might resort to praying Novenas (a nine-day series of intercessions for a particular favour) to secure an advantage. Novenas are not unlike medieval charms in their promises of freedom from physical and spiritual ills if recited according to the correct form and for the prescribed number of times. In this sense, vernacular healing exhibits a vigorous continuity. What is discontinuous are the ruptures and breaks in the world of official religion and medicine. After the Reformations, clear ruptures appear in the seeming continuity of belief and confidence in the efficacy of vernacular (as opposed to official medical or church-approved) healing systems. Changes in theological and scientific belief affect the way in which

vernacular healing is perceived.

Tambiah sees three streams coming together in the sixteenth and seventeenth centuries: the Protestant reliance on self help which encouraged the rise of capitalism, the scientific revolution and Protestant Calvinist cosmology. This cosmology saw God as omnipotent and unimpeded and acting according to his providence. God acts according to the laws of nature, and miracles, though technically not impossible with God, are unlikely. These beliefs encouraged the pursuit of science and applied science. Thus Protestant theology and modern science were allies in a rupture with past ways of thinking (Tambiah, 1990, 11-18). Protestant thinking about illness focused on its cause: it may be given by God as punishment or test, and thus must be borne nobly. The way to handle it was to pray directly to God, thanking him. The role of the physician was to be an agent of God as medicine was a divine vocation. Puritans, however, did not believe that medicine alone cured and, in fact, thought that God could stop the action of medicine if he wished (see Thomas, 1971, 318; Harley, 1993, 101-107).

Ruptures are particularly in evidence after the Protestant and Catholic reformations. What had been held to be true fact up to that time was now seen as superstition. The power of saints' relics to heal and the real presence in the Host, became, to the Protestant reformers and their descendents mere superstition. The Council of Trent (1548-63) was convened both to reassert Roman Catholic belief in the face of the Protestant assault and to clean up many of the practices now believed to be superstitious. Hence devotions to the host which were so excessive as to be considered heretical (a heresy is usually an exaggeration of something held to be true) were curtailed (see Attwater, 1930, 533).

The Calvinist reforms led to a paradigm shift in which all recourse to mediated healing

through relics, the prayers of the saints and the Mass was rejected. The puritans emphasized personal piety as a response to illness. With their profound belief in God's providence (God controls all minutiae of human life) they took the decidedly Augustinian stance that to consult oracles or astrologers to predict the future was a profound insult to God because it questions his providential care for his creatures (Thomas, 1971, 426).

Augustine had attacked the use of astrology to produce events but not to predict. By prediction, he meant such practices as predicting the weather, as this was part of natural science (Flint, 1991, 96). Following Augustine, the post-Tridentine Church attacked the use of magic to foresee the future or to produce it as it questioned God, attempted to know what is only knowable to God and denied free will (see Flint, 1991, 20).

Where Catholics differed from Protestants was in their acceptance of mediated healing which, in the post-Trent Church, could be hoped for when praying *through* saints, though not, of course, guaranteed. The distinction is subtle and it is easy to see how Protestants viewed Catholic use of sacramentals and saints as magical. The post-Reformation Protestant churches still held many beliefs dear to Catholics: witchcraft was considered to be a very real possibility as was demon possession. The difficulty, however, was that Protestants were now left vulnerable to bewitchment but without a shield against it. To ask people simply to rely on God's mercies and to offer a straightforward, heartfelt, unmediated prayer may have been demanding too much courage of some (see Thomas, 1971, 315, 316, 318). No matter how the Protestant divines of that day or this judged the matter, individuals after the Reformations still actively resorted to cunningfolk and some even asked Roman Catholic priests to exorcise their fields and houses, Roman Catholic priests, presumably, enjoying more sacred *mana* (Thomas, 587 and see 85). Protestants, deprived of their saints, often viewed the village cunningwoman, according to Thomas, as an alternative saint

(Thomas, 316). The cunningman or woman was a powerful rival to the Protestant minister because he or she offered mediated magic. But relying on prayer alone was accepted by Puritans.

Cunningfolk were liable for prosecution in ecclesiastical and secular courts from the sixteenth to seventeenth centuries. However, the use of so-called white magic in this era was less likely to be prosecuted. Charmers of this era might claim that they had simply used prayers -- a perfectly orthodox Protestant response (Thomas, 1971, 306, 318). Supernatural healing was believed to be illusory or satanic but after the Reformations this type of healing was viewed as less heinous a sin. It was considered to be on the same level as sabbath-breaking (Thomas, 306). By the seventeenth century, the Anglican church courts, which had initially shown excessive interest in cunningfolk practices redolent of witchcraft, displayed a diminishing interest. In a far cry from the position of the Inquisitors, they saw many of these practices as superstitious but harmless and futile (Thomas, 310).

Even after the Reformations the local minister might still practice medicine and might still use folk healing methods. The danger existed, however, of relying too much on the automatic efficacy of prayer -- a belief closer to the Catholic concept of *ex opere operato* (the supernatural effect of a sacrament is independent of the virtue of the person administering it). The Royal College of Physicians in 1606 had intervened to prevent the Rev. John Bell from treating a fever with words written on paper (Thomas, 1971, 328). It would seem that, even after the extreme discontinuity of the rejection of mediation through saints and sacramentals, not all felt the power of self-agency that Thomas attributes to the average person of this era. Illness is not easily conquered, no matter how hard one tries. Self-reliance did not deal a death blow to popular healing magic and, in spite of Thomas' belief (evident in his final chapter) that such healing is now resorted to only by the gullible,

it endures. The Protestant Reformations introduced other types of activity Thomas calls magical -- emphasizing the role of religion in healing and prophesying. Some of the followers of the Quaker George Fox even claimed to be able to raise the dead (Thomas, 1971, 149-150). Puritans resorted to lot-drawing in the form of *Sortes Biblicae* (*Sortes Sanctorum* or cutting the bible). As Meredith McGuire suggests in *Ritual Healing in Suburban America*, illness can pose such a threat that the educated will resort to vernacular healing even when orthodox medicine is available. This confirms Thomas' assertion that people resort to magic when they perceive that they cannot control the universe as much as they think they should be able to. No matter how sophisticated modern medicine has become, not all diseases can be cured and some old ones (tuberculosis, streptococcal infection) have returned with a vengeance.

Many Protestants were expelled from or fled England after the Reformations because of their non-conformist beliefs. In attempting to fit concepts of folk religion to American life, Don Yoder examines the view that the Protestant folk religion of the American colonists "consist[ed] of survivals carried over by the people from medieval European Catholicism." He suggests the possibility that official Protestantism was so austere that it forced people to develop magico-religious healing as a form of folk Protestantism (Yoder, 1990, 77). This is a view that sees ostensibly non-rational beliefs and practices as survivals from an earlier stage of culture which, by rights, should have been superseded by more rationally based beliefs. Richard Godbeer, in *The Devil's Dominion: Magic and Religion in Early New England*, sees seventeenth century Protestant magical practices as evidence of inconsistencies between the profession and practice of their faith (Godbeer, 1992, 8).

Among the early settlers in New England, ideas which are not normally associated with Puritan Protestantism abounded. David D. Hall, in *Worlds of Wonder; Days of Judgment*,

says that he was surprised to discover that magical beliefs were common among early New England settlers. Beliefs in prophetic dreams, ghosts, divination, witchcraft and evil spirits were common. Many household almanacs, most of which were written by the clergy, offered items of astrology (Hall, 1990, 19, 7). Written prayers posted at the back of chapels took on the quality of amulets.⁴⁶

A study of these shifting relationships between popular healing and official attitudes is important to an understanding of modern healing practices. One element is continuous -- that of competition, as is syncretism -- particularly when aspects of practice appear to be survivals of earlier practices now used in a different way. The leeches competed with the saints; the clergy competed with doctors as healers using both natural means and supernatural; cunningfolk competed with the Protestant ministers; alternative healers today compete with modern medicine. And it would appear that modern medicine, when it tries to incorporate alternatives into its therapies, is trying to "baptize" them and thereby rescue them from the heretical fringe. The Catholic Church still firmly condemns the use of magic for any reason, reiterating the official position in its most recent catechism. Pentecostals, evangelicals and Catholics in the charismatic movement are most conscious of this and reject many forms of alternative medicine as demon-inspired, as a glance at evangelical literature, both Protestant and Catholic, on New Age "conspiracies" makes clear.

Vernacular healing practices have survived even the scientific revolution. As noted in the

⁴⁶"...it was also common practice to request a special prayer (or mention in a prayer) in Sunday services. These requests, handwritten on small slips of paper known as prayer notes, were posted in a church or given to a minister. Lacking kings to heal by touch, people in New England viewed these bits of paper as possessing special efficacy. When Samuel Sewall 'asked [a sick man] whether I should put up a Note for him' his response suggests the folk perception of these texts: 'He seem'd very desirous of it; and said he counted it the best medicine'" (Hall, 1990, 200).

introduction to this chapter, history is seen by such philosopher-historians as Foucault as a series of ruptures and discontinuities. Remnants of the forgotten past weave their way through practices of the present but a particular difficulty in attempting to link healing practices of the past with alternative healing practices of the present is to assume either a natural progression or a phenomenological continuity.

While people still believe in the numinous power of stones or crystals (crystals are believed to channel energies from the universe), use amulets as protections against danger (rabbit's foot; miraculous medal, saints' relics) and engage in other practices that seem structurally similar to those of the past, is this a phenomenological continuity or are these objects and practices used with different intentions? The world of the twenty-first century and its beliefs are radically different from those of our distant ancestors. Nonetheless, many practices seem remarkably similar to those of biblical days. For example, physician Larry Dossey speaks of the use of prayer cloths which are laid on a sick person. These cloths are first held by people who pray while holding them and then are laid on the diseased part of the patient's body (Dossey, 1999, 126). This is a type of sympathetic magic of ancient provenance. In the bible, the hemorrhaging woman is healed by touching Christ's garment (Matt: 9:20-23) and the Acts of the Apostles describe healings from handkerchiefs or aprons that had touched Paul's skin (Acts 19: 11-12). Dossey also describes a healing identical to those of the distant past in which people seeking healing slept in tombs and temples (called incubation) so as to be healed, or drank herbal teas made from the grass covering a saint's tomb. In the modern era, a small girl was healed of leukemia in 1952 after she was laid on the tomb of a nun who had died. The nun was Mother Elizabeth Seton and this miracle was one very important event that led to her canonization (Dossey, 143-144).

What is discontinuous is the attitude of Church and state. Modern divines seem to be far

less preoccupied with alternative healing practices (with the exception of some extreme Protestant and Catholic groups) than those before the seventeenth century. Our cosmology has changed. Whereas demons still hovered through the air of the seventeenth century, we are far less likely to accord so much power to them, or indeed, to believe in their existence at all. One could say that changes in the way vernacular healing was perceived were gradual from the tenth to seventeenth century and that these practices only entered the periphery of society after this time.

Rituals are most powerful and most popular when embedded in and sanctioned by a believing community. Many no longer live in such communities. Practices that seem structurally similar to those of the past are offered as products on a consumer market. One can sign up for ten-week courses in healing or buy crystals and sacred stones at the local health food store. Modern seekers of health and healing go outside their communities when they reach for their credit cards to order sacred objects on-line or on the home shopping channel and when they go outside their own religious traditions in the hope that some traveling healer will rescue them.

The nineteenth century saw the flowering, particularly in the United States, of new religions such as Christian Science, Pentecostalism, Seventh Day Adventism and new spiritual and healing movements. Belief in the sacred did not disappear but was relocated in movements that could be described as a form of popular Protestant Christianity. The New Age and Human Potential movements of the twentieth century borrowed many ideas from the metaphysical and transcendental movements of the nineteenth. While ostensibly in opposition to the scientific rationalism of conventional medicine and the “irrationality” of religion, adherents of New Thought in the nineteenth century, and of the New Age in the twentieth, used scientific theories and language to bolster spiritual claims. Christian

Science, a nineteenth century healing religion, claimed to be a science; physician healers such as Richard Gerber and Deepak Chopra in the twentieth century argued their theories by referring to the quantum theory of physics. Larry Dossey strongly approves of studies of prayer using the gold standard of research -- the double-blind, placebo-controlled clinical trial. This is a topic of current medical interest that has featured in the pages of the *Archives of Internal Medicine* (Oct 25, 1999; June 26, 2000).

Conclusion

Some find it tempting to dismiss the syncretistic combination of science with metaphysical ideas about healing as pseudo-science or quackery. To do so would be to lose sight of the very real attempts by some physicians to bring the soul back into medicine. One need not embrace all forms of alternative healing as intrinsically good but neither would it be wise to reject that which might be worthy of complementing established forms of healing. Many forms of alternative medicine will not and should not join biomedicine but they might still be promoted as safe and effective alternative or complementary methods of benefit to society and its individuals.

As this chapter pointed out, some forms of alternative medicine are revivals of earlier types of folk or popular medicine while others are part of a continuous religious or folk tradition. The next chapter will focus more closely on religious and spiritual influences on the many diverse types of alternative healing.

Chapter Six

Religious and Spiritual Influences in Complementary and Alternative Medicine

Introduction

From ancient times, people have tried to explain illness and to cure it. Serious illness strikes at the heart of our sense of bodily identity because it forces us to face the possibility of our personal non-being on this earth. All religions and cultures have devised ways to make sense of illness and to situate illness and healing in a broader, spiritual, context. It is no wonder that so many societies have gone beyond the material world in an attempt to make sense of a very material event. Illness attacks the body, but it does not leave the soul untouched.

Not only the rituals but the healing encounters of alternative medicine have religious elements. While patients may place great trust in conventional doctors and, in the case of psychotherapists, become so attached (through the mechanism of transference) that informed consent may be somewhat impaired, some practitioners of alternative medicine may be much more like shamans or priests than technically oriented modern doctors. This is particularly so when healing is exercised in a group. The client may be committed to a group or movement.

Anthropologists and sociologists have analyzed the structure and function of religion in a way that makes sense of the connection between religion and healing. One concept, relevant to a discussion of alternative medicine, is that of “excursus religion” in which religious rituals are severed from or were never a part of an established religion. This idea has

parallels in the relationship of alternative medicine to established medicine. Another important idea is that of unchurched religion. Sociologist of religion Robert Fuller uses this term to describe the way in which complementary and alternative medicine can function for some people -- as a private way to a religious type of transcendence. Some associate complementary and alternative medicine with a particularly Protestant sensibility in its emphasis on private revelation, its anti-authoritarian history and in its Puritan-influenced seeking after perfection. Linked to these concepts is an idea that dates back to Weber who so accurately described a world that had, by the late eighteenth and early nineteenth centuries become secularized and disenchanted of the notions of wonder and the miraculous so dear to popular Catholicism and the traditional Catholic world view. One might even ask if the current interest in complementary and alternative medicine is a partially disguised interest in religion -- a path along which people may find a way back to belief in the unseen, hope in the miraculous and confidence that salvation from suffering can be found in a ritual with meaning. Many popular writers speak of illness as a spiritual journey. When an experience of sickness and disability is reframed as an opportunity for growth, healing methods that promise transcendence will seem overwhelmingly seductive. This chapter will look at these and related issues.

Complementary and Alternative Medicine and the Sociology and Anthropology of Religion

Sociological and Anthropological Definitions

Sociologists and anthropologists of religion have defined religion as a way in which people deal with the perilous unknown. Weber saw religion as providing the promise of salvation from suffering while, at the same time, explaining it (see Weber, 1913/1915, 267-301).

Theodore M. Steeman draws from Max Weber's works the following definition:

[Religion is] man's continuous effort to deal rationally with the irrationalities of life. Religion arises out of the *not* (needs) of existence, its ambiguities and conflicts, and gives people the necessary *begeistrung* (enthusiasm) to live. It is concerned with the problems of ultimate meaning and with the promise of the fullness of life. It makes life's precariousness acceptable, gives life preciousness and prescribes a way of life which makes living worthwhile (Steeman, T.M., Max Weber's Sociology of Religion, Sociological Analysis, Vol. 25, 1964, 56, quoted in O'Toole, 1984, 136).

Thus Weber saw religion as meeting an important psychological need: it gives meaning to suffering (theodicy) and provides salvation from it.

The anthropologist Bronislaw Malinowski said:

Religion is not born out of speculation or reflection, still less out of illusion or misapprehension, but rather out of the real tragedies of human life, out of the conflict between human plans and realities (Malinowski, 1931, 45).

Emile Durkheim defined religion as:

a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden -- beliefs and practices which unite into one moral community called a Church, all those who adhere to them (Durkheim, 1915, 62).

Using these definitions, can we say that some forms of complementary and alternative medicine are related to religion when they attempt to give illness meaning, make the fear of suffering acceptable, explain tragedy, offer a system of beliefs and rituals that invoke the healing powers of sacred or transcendent beings and join sufferers in the embrace of a supportive community?

Chapter four addressed the many reasons behind the use of alternative medicine. One potent attraction is its promise of "wholeness" which may be linked to deeply felt religious yearnings. The desire for individual wholeness is linked to a desire for universal harmony.

In this sense, those types of alternative medicine that form part of the holistic health movement,⁴⁷ could be seen as salvation religions (see Hanegraaff, 1998, 44-45 and Fuller, 1989, chapter 6). Alternative medicine is considered to be part of the holistic health movement which, according to Hanegraaff, developed alongside the human potential movement and shares much of its beliefs. The human potential movement views body, mind, feelings and spirit as intertwined. Illness disrupts these connections and healing restores wholeness. The holistic health movement emphasizes the role of the mind in both creating and curing illness. Illness can be an opportunity for personal growth because it can lead the individual to search for the “deeper *meaning* of his/her illness...” (Hanegraaff, 53-54).

Larry Dossey takes this idea one step further in his definition of what he describes as Era III medicine. In Era I, he says, the emphasis was on the physical aspects of medical care. Era II focuses on the mind's effect on the body but it is still concerned with the application of one doctor's treatment to one individual patient. Era III he describes as non-local medicine in which healing prayers, thoughts and intentions are directed to individuals or groups across great distances. Era III medicine, he says, transcends the self. One form of medicine does not replace earlier types as all three can be used simultaneously (Dossey, 1999, 19, 223-224). For example, a person with asthma might be given medication (Era I), psychological support on the grounds that asthma is exacerbated by emotional distress (Era II), followed by the prayer therapy of Era III.

Modern medicine, with its compartmentalizing of the human body and its corresponding diseases, contributes to the unnerving sense of fragmentation that illness brings. When the

⁴⁷ Although osteopathy and chiropractic might be included as practices within the holistic health movement it is difficult to see them as a type of salvation religion. Modern chiropractors and osteopaths do not generally (although there are sure to be exceptions) explore spiritual or transcendental issues with their clients.

oncologist tells the patient “there is nothing more that I can do” and dismisses her, the patient will probably feel abandoned and turn to an alternative practitioner not so much for cure as for a sense of connection and support. That is why people dying of cancer may still exhibit more gratitude towards the alternative practitioner than to the medical doctor, according to Robert Buckman (see Buckman, 1993, 153-154).

The sociologist Meredith McGuire, in her article *Religion and Healing the Mind/Body/Self*, discusses the way in which the human body expresses itself through symbols and language. Every culture has ways of expressing spiritual and emotional distress by use of body metaphors. This is what anthropologists mean when they speak of the social body. Latin Americans speak of “nerves”(a feeling of anxiety, of “going to pieces”); Iranians speak of a “pressed heart” (McGuire, 1996, 107-108 and see Hellman, 1990, 97). In Western culture, we carry heavy loads on our backs. The body is a “natural symbol” in Douglas’ term (Douglas, 1966, 1970) and illness a metaphor for suffering in social relationships. Healing comes about “when body metaphors and symbols are ritually realigned or reconnected...” (McGuire, 1996, 107-108). Healing rituals may effect a transformation of the whole self, working by “symbolically accomplishing real effects...” (Csordas, 1994; Desjarlais, 1992; Kapferer, 1993; Lock 1993; Stephen, 1989, in McGuire, 1996, 108).

Illness is social as well as physical and, in many ways, is defined by culture or the medical profession. Until 1973, homosexuality was an illness according to the American Psychiatric Association. An infertile woman may define her barrenness as an unfortunate quirk of nature but may live in a society that regards it as a serious but (for the economically well-off) treatable illness. Manufacturers of hormones see menopause as an estrogen deficiency disease whereas groups of self-described “crones” gather to conduct rites of passage and rituals of celebration. As Roy Porter says, “illness is...not just biological but social, and

concepts of the body and its sicknesses draw upon powerful dichotomies: nature and culture, the sacred and the profane..." "What is considered normal health and what constitutes sickness or impairment are negotiable, Maladies carry different moral charges" (Porter, 1997a, 35-36).

Complementary and alternative medicine, insofar as it explores the symbolic, social and moral aspects of illness, addresses these deeper needs in a satisfactory way.

Many people speak of alternative medicine as if it were a single type of medicine. Yet its diversity makes categorization difficult. What many do not recognize, a medical professional writes in the *Journal of the American Medical Association*, is that all have in common an integral spirituality (Eskanizi, 1998, Nov, 1621-1622).

Engaging in rituals of healing may have a very profound effect at a deeper, biological level. McGuire suggests that the total involvement of the body in such rituals as meditation, or the "collective remembering" of the Passover Seder or Eucharist, may reach down through the very tissues of the body to the soul. When individuals gather to share a religious/spiritual/healing experience, the very sharing can create a powerful charge (McGuire, 1996, 109-113). This type of experience is often perceived to be absent from conventional churches when powerful rituals, like the Eucharist, are conducted in a perfunctory manner.

Complementary and alternative medicine uses language that is full of hope and poetry. It appeals to those looking beyond what they see to be the arid language of science (which nonetheless often describes greatly creative ideas and inventions). While one may describe some alternatives, such as chiropractic, acupuncture and homeopathy, in scientific terms,

they can, according to Kaptchuk, Edwards and Eisenberg, referring to Tambiah's 1990 work, be "framed in terms of solidarity, unity, holism and the sense of encompassing oneness" (Kaptchuk, Edwards and Eisenberg, 1996, 59)

Kapchuk, Edwards and Eisenberg describe the world of complementary and alternative medicine as "filled with benign, benevolent, and intentional forces. The *innate intelligence* of chiropractic, the *qi* of acupuncture and the *vital spiritual force* of homeopathy have persuasive rhetorical effects." When people are at their most fragile, they say, these systems "connect a person in a web of words and a dramatic ritual of actions to a persuasive experience of a cosmos concerned with human welfare, intelligent and infinite in resources" (Kaptchuk, Edwards and Eisenberg, 1996, 59-60).

This way of understanding illness helps people to relate differently to the experience and offers hope and meaning. According to Kaptchuk and his co-authors, alternative medicine places the experience of illness "in a cosmic drama of vital energies that can be nurtured, fostered, and fully embraced" and allows sufferers to feel deeply connected to others and the universe at a time when they are most fragile and vulnerable to psychic isolation (Kaptchuk, Edwards and Eisenberg, 1996, 59).

When an alternative medical practice functions in this fashion, one can readily see how a person suffering from a debilitating illness can draw real hope that salvation from suffering is imminent. Most forms of complementary and alternative medicine address suffering in a way that technically-oriented conventional medicine cannot, give meaning to the irrationality of suffering (to use Weber's theory); make sense of tragedy; (Malinowski) and, in many cases, provide a supportive community (Durkheim) that can function as a type of excursus religion, to use Robert Ellwood's term. The next few paragraphs will look at excursus

religion in general. This will be followed by a more detailed examination of those types of complementary and alternative medicine that are specifically spiritual. This section of the chapter will conclude with a discussion of the influence of Protestantism and secularization on the “disenchantment” of the world.

Complementary and Alternative Medicine as a type of “Excursus Religion”

The intense type of healing rituals described by Meredith McGuire in *Ritual Healing in Suburban America* are examples of “excursus religion” -- a type of religious experience found outside the conventional churches. While one cannot point to any single type of alternative medicine and call it a religion, many types of complementary and alternative medicine are examples of excursus religion -- a type of religious seeking that leads away from established religion (see Ellwood, 1979, 21). Robert Ellwood believes that the American spiritual tradition is one of optimism -- a belief that how one thinks and approaches problems has an effect on and can transcend suffering (Ellwood, 1979, 25-26). Healing groups that appeal to the powers of transcendental spirits as well as to the power of the group may nurture such optimism and, as McGuire believes, have an effect on the physical body.

Healing groups can be seen as a type of excursus religion because they conform to at least two defining requirements: they do not compete with conventional religions and they offer one simple but effective and powerful ritual.

Excursus religions do not set themselves up in opposition to conventional religions like Judaism or Christianity. They claim to complement official religion by focusing more keenly on one aspect -- such as healing -- that receives only general attention from

established religions (Ellwood, 1979, 32-33).

Many excursus religions offer “a single, simple practice” which can lead to an actual or perceived change and can be engaged in outside the confines of a conventional church. Furthermore, excursus religion welcomes and has a high percentage of participants who engage in the practices and rituals without either joining the group or adhering to its doctrines. Many Catholics and Jews practice yoga and meditation without joining an ashram. People with tenuous affiliations to the Catholic church might participate in a healing mass. These practices are not engaged in to define or reinforce social identity (which might be the case with someone participating in Yom Kippur services, the Sacrament of Penance or saying the Rosary) but to positively affect the person performing the ritual (Ellwood, 1979, 36, 34). In this sense, excursus religions do not bind people into the moral community of the church, to use Durkheim’s definition, nor even to the group. Rather, they can promote a sense of separateness and liminality.

Fuller asks how unorthodox systems of medicine and religion “turn healing into a religious ritual and thereby set a curative process in motion.” Theories of the secularization of North American society point to the decline of religion as a result of the growth of science and technology and greater cultural and religious diversity in Western society. Fuller describes four ways in which secularization is supposed to have changed the way religion functions in the modern world: the decline of religious authority, prestige and influence on society; the tendency of modern religion to pay more attention to enhancing day-to-day life rather than focusing on the the life to come; the “privatization of religion” and the “desacralization of Western world views” (Fuller, 1989, 118-119).

The privatization of religion gives rise to an association between religion and narcissism,

according to Donald Capps (Capps, 1985, 242, cited in Fuller, 1989, 137). This can lead to movements that enhance personal life. Fuller refers to the psychologist of religion Peter Homans who believes that many modern people find it “difficult to ‘idealize’ adequately the God of institutional religion...” (Homans, 1979, 194, cited in Fuller, 1989, 137). They may turn to unorthodox medicine to mediate the sacred.

The growth of excursus religion, and the spiritual movements that are a part of this phenomenon, correspond to an apparent decline in conventional religions. This is often put forward as evidence that conventional religion has moved to the periphery of society but it does not mean that religion has disappeared. Secularization does not lead to loss of religious belief or expression. It does mean that religious experience tends to become divorced from the structures that contained it. Religion then flourishes as a subjective experience and in small groups (Ellwood, 1979, 171). Many people, for example, maintain a strict yoga and meditation practice, often living lives of great discipline and self-abnegation without ever joining a conventional church.

Ellwood sees this movement to subjective religious experience as a return to folk religion. In his view, folk religion does not engage in dialogue either with official science or official religion but “dwell[s] with its own nonhistorical, and nonliterary -- in the cultural sense -- joys and apocalypses.” This, he says, is the inevitable result of the detachment of religion from the institutions (such as medicine and education) that it once nourished. According to him, the two worlds -- that of the “great tradition” of official religion and the minor practice of excursus religion -- “drift apart, until they become nearly invisible to each other.” One could say that, in a similar fashion, alternative medicine drifted away from the “great tradition” of conventional medicine (for example, until the early twentieth century, homeopathic schools of medicine co-existed with those that evolved into our modern

schools of medicine). Ellwood concludes his book by saying that dominant religion is aware of excursus religion through the promotion of Eastern religions via yoga and meditation and is thereby challenged (Ellwood, 1979, 173).

Ellwood wrote his book more than twenty years ago. Since that time, many conventional religious denominations have accepted small, excursus -type groups into their structures (the Roman Catholic Charismatic Renewal movement, once on the periphery of parish life, is usually listed in the church bulletin along with programs like A.A. and the St. Vincent de Paul society). Paralleling this development, conventional medicine has incorporated aspects of excursus religious practice, and what could be described as excursus medical practice, into the conventional setting. Excursus religious groups may also function in a conventional hospital. For example, patients in some hospitals, particularly those in palliative care units, are taught meditation techniques. A medical yoga program is offered to medical students at Jefferson State Medical School. Nurses practice Reiki and Therapeutic Touch on hospital wards. Acupuncture and chiropractic, which, like excursus religion, focus on a single technique, have been licenced in many provinces and are treated as if they were a part of conventional medicine.

Thus the circle turns and what was separate, set apart, split off, joins the “great tradition”. The danger is that excursus practices, adopted into the mainstream, can be robbed of their mystery and become mere techniques. Modern hospitals and modern medicine are not holistic. This is not a criticism but a description. Just as medicine is divided into specialities, so too are hospital workers and hospital wards. Inviting holistic practitioners into the conventional setting does not render care holistic but makes alternative medicine just one more treatment method in a system of disconnections.

One of the gravest dangers of inviting alternative medicine into the conventional setting is the possibility that alternative medicine will not only lose its alternativity but will be robbed, at its core, of its numinosity and healing power. As William James said of Mind-Cure, if it “should ever become official, respectable, and intrenched, these elements of suggestive efficacy will be lost” (James, 1902, 114). On the other hand, it is the numinosity of alternative medicine’s spiritual core that creates the greatest ethical problems when it is introduced into a hospital as “just another form of treatment”. Is it ethical to force a spiritual practice into biomedicine’s straitjacket? Conversely, are hospitals derelict in their duty to patients if they permit a variety of spiritual practices to be offered as “just another treatment”? This could be construed as deceptive. The next section will examine in more detail the spiritual aspects of complementary and alternative medical practices.

The Spiritual Aspects of Complementary and Alternative Medicine: “Unchurched” Religion and Metaphysical Healing Movements

When people think of the ethics of religious forms of healing, they tend to focus on the right of the individual to refuse medical treatment in favour of a religious alternative and the even more difficult issue of the right of a parent to choose religious rather than conventional healing for a child. Extensive arguments are to be found in legal and ethics literature. Yet a more subtle ethical difficulty lies in the use of types of alternative medicine which are not explicitly religious. One must ask how informed is the consent of the patient who goes to a naturopath who grounds his theory in spiritual concepts, for example. As noted before, Fuller says that his work focuses not on religious groups which dispense healing, but on “medical systems that dispense heavy doses of unconventional religion.” (Fuller, 1989, 11). His interest is in those modes of religion which not only have survived, but thrive, in the alternative medical systems of our secular society.

Fuller views a number of contemporary holistic healing methods as frankly religious, combining aspects of Eastern⁴⁸ religions with an American metaphysical tradition.

Metaphysical movements hold that a type of divine energy exists from which humans may draw healing power. These metaphysical traditions blur distinctions between the spiritual and the material world (Fuller, 1989, 96-97).⁴⁹

Metaphysical healing movements are grounded in the idea that invisible forces, not

⁴⁸The popular belief is that New Age philosophies and healing practices have their origins in Western attraction to Eastern religions and ideas. As Hanegraaff points out, ideas from the East have been adapted by Western esotericism but “only in (sic)sofar as they could be assimilated into already-existing western frameworks.” “The Orient has functioned mainly as a *symbol* of ‘true spirituality’ and as a repository of exotic terminology; its *ideas* have not fundamentally changed those of Western recipients” (Hanegraaff, 1998, 517).

Hanegraaff points out that nineteenth century transcendentalists found Oriental religions intriguing and theosophists like Helena Blavatsky synthesized Eastern ideas with Western occult philosophies (Hanegraaff, 1998, 462). Versluis saw the attraction to Eastern religions as a result of the Western need to believe in progress but this belief in progress was “its greatest obstacle to actually understanding Asian religions” (Versluis, *American transcendentalism*, 1993, in Hanegraaff, 462).

Fuller, likewise, emphasizes that we must not become distracted by the seemingly strong influence of Eastern religions on popular American healing movements. Religious ideas from the East merge happily with “convictions endemic to America’s unchurched metaphysical tradition” and books on holistic healing do not make distinctions among various Eastern teachings but are inclined “to assume that their primary teachings are essentially identical with the parapsychological beliefs associated with Kirlian photography or out-of-the-body experiences...” All of them point to a universal energy that affects all living creatures. What these Eastern philosophies do for the followers of various American healing systems is provide “legitimation of their belief in the existence of ‘subtle energies’” and of the possibility of contacting other realms through meditation. The diverse Eastern traditions include “the coinherence of the physical and spiritual realms of life, the progressive or evolutionary character of an immanent divine force, and the primacy of certain altered states of consciousness for attuning humans to this divinely guided evolutionary flow” (Fuller, 1989, 96- 97).

⁴⁹The term “metaphysical movement” was coined by J. Stillson Judah in 1967. Judah included spiritualism and theosophy in his list of metaphysical movements but Hanegraaff restricts the term to New Thought groups. Hanegraaff notes that the term has been applied to post-1945 movements in the New Thought tradition (Hanegraaff, 1998, 445; Judah, 1967, Wagner, 1983, in Hanegraaff, 1998, 455-456).

recognized by conventional science, may harm or heal. Those who hold these beliefs often have experiences that lead them to believe in the power of the invisible. They may, for example, use affirmations (“My pain has gone and I am filled with divine energy”) and experience a feeling of oneness with the universe. Metaphysical healing movements persist in our own day of so-called scientific achievement and among the educated because their healing rituals connect people to the sacred, according to Fuller. As William James said of Mind-Cure, metaphysical healing systems offer tranquillity and are as effective as scientific methods against certain diseases (Fuller, 1989, 6-8; James, 1902, 122). This remains true, particularly for diseases with a strong psychological component.⁵⁰

Fuller’s central point is that alternative healing systems place supernatural beliefs outside the official Christian church and, as such, remind Americans that many of their religious beliefs are of the “unchurched or ‘folk’ variety.” In other words, a type of excursus religion. Those who hold these metaphysical doctrines believe that higher realms exist and that, under certain circumstances, divine energy flows from these higher realms to the lower, earthly plane. Humans can commune with these energies and also channel these energies to one another, resulting, to use historian Sydney Ahlstrom’s phrase, in a “rapport with the cosmos”. Many alternative medical systems attempt to provide “empirical evidence” that such higher energies can effectively heal (Fuller, 1989, 8-9; Ahlstrom, 1972, 1019). To use a simple example, if a person with a stiff shoulder visualizes divine energy pouring into the joint (sometimes by seeing a ball of light focused on the body), the joint may well relax.

Fuller claims that “alternative therapies perpetuate religious and metaphysical thinking... .

⁵⁰Individuals with diseases not recognized by medical science often turn to alternative medicine because they are sometimes treated as neurotics by conventional medicine. Those who believe all alternative medicine functions as a placebo then attempt to “prove” this theory by pointing to the imaginary illnesses that it cures.

Clients may turn to alternative therapists to alleviate pain but, he says, “they may also be looking for metaphysical reassurance” (Fuller cited in Crigger, 1993, 3). He says:

Patients often consult a doctor for more than the remission of their symptoms; they often also seek relief from the fears that have been aroused by their illness, and they seek ways of interpreting the reasons for their having fallen out of favor with the cosmos. By giving patients confidence that they have inwardly reconciled themselves to the ultimate powers upon which life depends, alternative healing groups make possible the restoration of a coherent sense of self” (Fuller cited in Crigger, 1993, 3).

Complementary and Alternative Medicine, Protestant Christianity and the “Disenchantment” of the World

Although alternative healing systems practiced today are viewed as part of a secular, not sacred world they are, in their origins, not only the inheritors of ideas rooted in antiquity but could be seen as an expression of popular Protestant Christianity. While Protestantism may seem, at first, an unlikely repository of popular religious practices (unlike Catholicism, with its saints, sacraments and sacramentals used to mediate healing power), Roy Porter sees alternative medicine and Protestantism as inextricably linked. Alternative medical ideas were a direct challenge to authority even before the Reformations. Paracelsus, in the sixteenth century, challenged the Galenic orthodoxy of the day and insisted that medical books be translated into the vernacular so that ordinary people would know how to heal themselves. Nicholas Culpeper outraged the physicians of the seventeenth century by translating physicians’ handbooks into English for use by a lay public. Roy Porter sees a “Pelagian or radical Protestant streak” in nineteenth-century healing movements. This desire to deliver humankind from disease found its ultimate expression in Mary Baker Eddy’s Christian Science movement which rejects disease as an ontological reality (Porter, 1997a, 209-210, 395). Wouter Hanegraaff, studying American healing systems, sees in them the belief that perfect health includes worldly prosperity (Hanegraaff, 1998, 47) -- which is connected to the Calvinist belief that the goods of creation are showered on the

Elect.

Even modern conventional medicine, according to Stephen Fulder, is a product of "Protestant science." He says that modern medicine is the creation of a world in which nature obeyed discoverable laws which could be used for human improvement. Alternative medicine, on the other hand, is not "just another modern technique, equivalent to physiotherapy." It has as much in common with prayer as it does with medicine, he says (Fulder, 1996, 7).

Fuller grounds North American preoccupation with alternatives to biomedicine in a Puritan utopian belief in infinite perfectability and the need for individual purification and regeneration. New England puritanism fused with the theosophical and spiritualist beliefs of the nineteenth century American fringe to create a metaphysical medicine (Fuller cited in Crigger, 1993, 3).

Fuller describes psychologist of religion Peter Homans' belief that "unorthodox medical groups can function as a kind of cultural successor to classical Protestantism for some modern Americans" (Homans in Fuller, 1989, 136). A topic for another study would be whether or not Catholics and Protestants approach the use of alternative healing systems differently, based on their different attitudes to sacraments, sacramentals and the way in which sacred power is channeled.⁵¹

⁵¹ Catholic belief is no barrier to heterodox beliefs. Catholicism may even, in some cases, provide fertile ground for decidedly unorthodox understandings of Christianity. A 1986 survey in Québec found that 15% of practicing Catholics who held traditional Catholic beliefs also believed in reincarnation, astrology, extra-terrestials who dwelled with God, the angels and the saints. Three out of four believed in paranormal phenomena (Bergeron, Bouchard, Pelletier, 1992, 57).

Max Weber, in *The Protestant Sects and the Spirit of Capitalism*, spoke of the “disenchantment of the world” (Weber, 1906, 302-322). A number of scholars have suggested that nineteenth to twenty-first century fascination with esoteric beliefs and healing rituals is a response to this disenchantment: to secularization, the mechanization of life which accompanied the industrial revolution and the subsequent loneliness of individuals. The nineteenth century was a time of progress but also a time of loss. Religious beliefs that seemed immutable were, some scholars argued, based on faulty reasoning. Darwin proposed a theory of evolution which appeared to attack the biblical story of creation; Emmanuel Swedenborg had, in the eighteenth century, suggested that Scripture should be replaced with direct illumination; Bultmann and other biblical scholars attempted to demythologize the bible. The industrial revolution created enormous social change. Work, once a cottage and family based enterprise, separated individual family members who were forced to travel outside the home to labour long hours in factories under physically dangerous conditions. Individuals became isolated from one another.

Hanegraaff quotes an article by Antoine Faivre:

The industrial revolution naturally gave rise to an increasingly marked interest in the ‘miracles’ of science. ...Along with smoking factory chimneys came both the literature of the fantastic and the new phenomenon of spiritualism. These two possess a common characteristic: each takes the real world in its most concrete form as its point of departure, and then postulates the existence of another, supernatural world, separated from the first by a more or less impermeable partition (Faivre, “*What is occultism?*”, in Sullivan, Ed., *Hidden Truths*, 1987, 3-9 in Hanegraaff, 1998, 421).

Two nineteenth -century developments depended on the esoteric tradition: romantic religiosity and occultism. Romanticism, an important nineteenth century movement (though it began in the eighteenth), rejected compromise by attempting to re-enchant the world (Hanegraaff, 1998, 423). An example of Romantic religiosity is found in nineteenth-century

Catholic devotional movements, particularly the devotion to the Sacred Heart of Jesus.

Nineteenth-century scientific discoveries inspired optimism but also led to a kind of dread.

The “disenchanted” world led, according to Faivre, to interest in occultism (Faivre, “*Accès de l’ésotérisme occidental*”, 1986, 88, cited in Hanegraaff, 422).

One might see alternative healing movements that sprang from the Protestant tradition of Christianity ⁵² as a way of reclaiming some of the wonder and magic of the sacred world.

Sociologist Peter Berger viewed Protestantism as a religious development which unintentionally threw humans back on their own devices when it abolished agents of mediation. The world was

“denuded...of divinity in order to emphasize the terrible majesty of the transcendent God and it [Protestantism] only threw man into total ‘fallenness’ in order to make him open to the intervention of God’s sovereign grace, the only true miracle in the Protestant universe. In doing this, however, it narrowed man’s relationship to the sacred to the one exceedingly narrow channel that it called God’s word... (...the *sola gratia* of the Lutheran confessions). As long as the plausibility of this conception was maintained, of course, secularization was effectively arrested, even though all its ingredients were already present in the Protestant universe” (Berger, 1967, 112).

However, when, in the nineteenth century, some people questioned the word of God “the floodgates of secularization” were opened (Berger, 1967, 112). The loss of mystery and numinosity in everyday life may be one reason some turned to movements that promised not only healing but an emotionally satisfying contact with the divine. We will now turn to some spiritual and philosophical ideas that influenced many modern-day alternative healing movements.

⁵²Of course Catholics, Jews and members of other religions participate in alternative healing movements. Fuller’s point is that these movements are grounded in a particularly Protestant sensibility.

Philosophical Roots of Complementary and Alternative Medicine: A Brief History of Spiritual Influences and Ideas

The link between religion and healing -- historical influences

Healing and religion have always been closely associated. One of religion's functions is to provide a sense of wholeness and hope of salvation which is a type of healing. All religions offer, in their sacred books, healing symbols and holy or divine beings who offer healing (Hanegraaff, 1998, 44). In Christian history, practitioners were for many centuries often part of the official Church. During the Middle Ages, monks and priests practiced medicine and what people of later times would call magical healing arts (Kieckhefer, 1989, 57-58). It should be remembered however that, at that time, and, for many people right up to this century, much medicine consisted of herbal remedies and prayers.

Christianity played an enormously important role in the development of health care. Monks studied medicine and preserved and transmitted ancient medical texts. The first European hospitals were founded in monasteries which were the centres for medical knowledge up to the twelfth century. However the Church had some restrictions. Several Church councils in the twelfth century forbade monks and canons regular to study medicine for monetary gain; the Fourth Lateran Council in 1215 commanded clergy in major orders not to perform certain types of surgery; the mendicant friars (Franciscans, Dominicans) of the thirteenth century were permitted to study medicine in the new universities but were forbidden to take degrees. In the fourteenth century popes rallied behind physicians' attempts to suppress uneducated healers (see Siraisi, 1990, 9-16; 25-26; Kieckhefer, 1989, 63). In seventeenth-century England, some priests and ministers still combined medicine with clerical duties (Siraisi, 26).

The Church and the medical profession were closely intertwined. It was only from the seventeenth century on that religion and medicine grew apart.

Judaism always valued healing (Zimmels, 1952, 6). However, Joshua Trachtenberg says that rabbis were uneasy about the use of magic in healing. The Hebrew scriptures condemned magic and divination as these practices smacked of hubris -- a challenge to the claims of the one true God. Nonetheless, medieval rabbis said that magic used to heal was not to be forbidden as superstitious. The Talmudic injunctions against magic did not apply. Talmudic literature refers many times to charms used to heal wounds and diseases and even religious leaders used them (see Zimmels, 1952 and Trachtenberg, 1939). However, the Torah itself was not to be used directly in healing rituals. Hence, in the Middle Ages, while Christian women in childbirth might ask to have the actual text of St. John's gospel placed on their abdomens (the opening words of this gospel, *in principio erat verbum*, were considered to be particularly numinous), European Jewish women of the same period would ask only that the Torah scrolls be brought from the Synagogue and carried to the door of their room (Trachtenberg, 1939, 105).

The Koran says little about medicine and Islam initially accepted beliefs which attributed illness to spirits.⁵³ However, by the seventh and eighth centuries, growing orthodoxy led Islam to condemn the animistic beliefs and practices of folk medicine. However, from 632 (the date of Mohammed's death) on, individuals claimed that the Prophet or his companions

⁵³While Islam is well known for the scientific contributions of its three most famous medical scholars -- Muhammad ibn Zakariya al-Razi (865-925); Abu Ali al-Husayn ibn 'Abdallah ibn Sina (Avicenna, 980-1037) and Abu-l-Walid Muhammad ibn Ahmad ibn Muhammad ibn Rushd (Averroës, 1126- 1198), it also shared with other Mediterranean peoples animist beliefs which attributed illness to spirits. The evil eye could cause serious harm -- "fevers, madness and children's diseases". Evil spirits were kept at bay through incantations and charms (Porter, 1997a, 93-94; 96-100).

must have made pronouncements on specific issues. These pronouncements became known as *hadiith*. Healers who feared condemnation would thus claim support in the sayings of the Prophet. In a practice remarkably similar to the Christian and Jewish practices described above, the Koran, considered, like Hebrew and Christian scriptures, to be imbued with God's power, could be used to help women in childbirth. Certain verses were written on a slate, wiped off, and the water which had been used to clean off the words was given to the woman to drink (Porter, 1997a, 93-94).⁵⁴

The following illustrates the continuity of some ideas found in healing movements over the centuries. These ideas are implicit in the various practices of complementary and alternative medicine. They are: life energy; Cartesian-Newtonian vs Einsteinian universe; universal consciousness; esotericism and its related movements such as gnosticism, romanticism and theosophy.

A. Life Energy as a Spiritual/Religious Concept

The religious aspect of alternative medicine is particularly evident in the belief, held by many practitioners of alternative medicine, that all living beings are animated by a "life energy" or "vital force", not explicable in terms of mechanistic science, the balancing of which is intrinsic to healing (see Buckman, 1993, 77). Healing is the result of techniques which either enhance nature's own ability to achieve balance or draw on supernatural forces to

⁵⁴Some precedent for bodily incorporation of the words of scripture, which was common among Christians of anglo-saxon times, can be found in Chapters 2 and 3 of Ezekial: Ezekial hears a voice "open your mouth and eat what I give you. I looked; and a hand was stretched out to me, and a written scroll was in it. He spread it out before me, it had writing on the front and on the back, and written on it were words of lamentation and mourning and woe. He said to me, O mortal, eat what is offered to you, eat the scroll, and go, speak to the house of Israel. I opened my mouth, and he gave me the scroll to eat. He said to me, mortal, eat the scroll that I give you and fill your stomach with it. Then I ate it, and in my mouth it was as sweet as honey: (Ez 2: 8; Ez 3: 1-3, NRSV).

enter and balance the body. This doctrine, called vitalism, was long held by conventional physicians but its survival as a metaphysical concept after the nineteenth century may be, as de Certeau, in his discussion of the philosopher Bourdieu suggests, a seeking what is lost in the distant land of the past (de Certeau, 1984, 50).⁵⁵

The concept of “energy” is common to all folk medicine according to David Hufford (1988, 238). This energy or vital force is seen as the essential power that heals. Both folk and alternative medicine contrast positive energies with those deemed life-destroying or negative. In the natural world, negative energy may be created by people of ill-will; in the supernatural, it may be created by such entities as demons. The theory of magical contagion holds that energy exchange is possible and that negative forces can be transmitted by the use of such objects as dolls impaled with pins. A parallel theory believes that positive forces can be transmitted when the healer uses an object belonging to the sick person to focus prayer or healing thoughts (see Hufford, 238-239). Belief in energy transmission is very ancient. Just as medieval people often believed that one could transfer the negative energy of illness to a tree or animal, or use the positive energy contained in a saint’s relic to heal, so too might a modern healer hold a scarf belonging to the patient as she concentrates her positive energies to heal at a distance.

A modern example of the channeling of negative energies away from a group is a ritual described by the sociologist Meredith McGuire: a group of modern American women,

⁵⁵De Certeau says that we can often only see our “tactics” by looking at other societies. “They return to us from afar, as though a different space were required in which to make visible and elucidate the tactics marginalized by the Western form of rationality. Other regions give us back what our culture has excluded from its discourse. But have tactics not been defined precisely as what we have eliminated or lost? As in *Tristes tropiques* [by Claude Lévi-Strauss, 1958], we travel abroad to discover in distant lands something whose presence at home has become unrecognizable” (de Certeau, 1984, 50).

gathered for a healing session, try to draw negative energies to themselves and then plunge lit candles, to which the negative energies have presumably been transferred, into a bowl of water. The water is then poured outside into earth (McGuire, 1988, 222). This apotropaic ritual employs sacramental elements (the bishop plunges the Easter candle into the baptismal water at the Easter Sunday vigil) and ancient ideas which saw fire, water and earth as sacred and purifying substances.

Larry Dossey refers to the work of Bernard Grad, a McGill scientist who conducted experiments in which 37 mice, fed on a diet designed to produce goiters, were divided into a treatment and control group. A healer then held cotton wool in his hands over the next few days. Ten grams of cotton wool were placed in the mice's cages. The mice in contact with the "healed" cotton wool did not develop goiters at the same rate of the control group (Dossey, 1999, 43).⁵⁶ Other experiments conducted by Grad involved tests to see if a healer could transmit his power to wounded mice through cages sealed in paper bags and studies of plants watered from a beaker held by a healer (Grad, Cadoret and Paul, 1961; Grad, 1965).

Energy can also be blocked and many twentieth and twenty-first century healing systems attempt to release these invisible obstructions. Therapeutic Touch, in which the healer passes her hands either above or along the patient's body to seek out and rebalance "blocked energies", is based on the concept of invisible energies.

Some proponents of alternative medicine claim that Grad's studies (and Jacques

⁵⁶It is not clear what experiment Dossey is referring to. His footnote refers to Grad's 1965 paper "*Some Biological Effects of Laying on of Hands*", but this paper only refers to wounded mice and no transfer of energy to cotton wool is involved.

Benveniste's study on immunoglobulin E antiserum in a homeopathic dilution - see Davenas et al., 1988) support the doctrine of vitalism, undergirding the homeopathic theory that substances "remember" the energies once in them.

Some modern researchers have attempted to offer scientific explanations for the way in which vital force may function. Ernest Rossi, Ph.D., a psychobiologist, discusses research that may give scientific credibility to reports of faith healings by demonstrating how mind and body are linked (Rossi, 1993, 136, 217). In the nineteenth century, it was believed that brain and body communicated via the nervous system. It is now known that the body's messenger molecules make it possible for the cells of mind and body to interact. The experiences we have throughout life, along with their accompanying emotions, can "modulate" the immune system or autonomic nervous system (Rossi, 1993, 136). Candace Pert, a neuroscientist and research professor in physiology and biophysics at Georgetown University Medical Centre in Washington, D.C., has made the field of psychoneuroimmunology popular. In 1972 Dr. Pert discovered the opiate receptor (Pert, 1997, 61) and worked on the other peptide receptors that mediate between brain and body and affect emotion (Moyers, 1993, 177). She and her colleagues see neuropeptides as part of a "previously unrecognized psychosomatic network" (Rossi, 1993, 278). Traditionally, scientists held to the Cartesian belief that brain, body and emotions are distinct.

Vitalist ideas were not alternative prior to the eighteenth century. William Harvey, who discovered the circulation of the blood in the seventeenth century, did not see the body in a mechanical fashion. In his view, as Porter puts it, it was "moved by vital forces." Porter describes him as sharing with Aristotle "a teleological view of the body and the belief that its workings depended upon the distinctive soul" (Porter, 1997a, 215-216).

Vitalist ideas have strongly influenced American popular medicine, although Hufford claims these ideas come from the East (Hufford, 1988, 239) and are common to all the metaphysical healing movements that were described in the last chapter. Mesmerism called this vitalist theory animal magnetism; the founder of chiropractic, Daniel David Palmer, called it innate intelligence or “Innate”; naturopathy uses the phrase *vis medicatrix naturae*. Homeopathy, which seems closest to conventional medicine in that its practitioners diagnose and prescribe remedies, is based on the belief that each being, animal or human, is energized by a vital force and that illness is the result of an imbalance in these forces.⁵⁷

B. Cartesian-Newtonian versus Einsteinian universe

Important to any discussion of energy as a healing power is a consideration of a recurring theme in alternative medical literature: the opposition of the Einsteinian universe to the Cartesian/Newtonian one. Almost all popular writers who support the use of complementary and alternative medicine make reference to the Cartesian/Newtonian biomedical model which guides most conventional medical practice and contrast it with new ideas they claim are based on the theory of relativity and quantum physics.

In the seventeenth century Isaac Newton proposed that the universe, which includes the human body, is like a clock. Every aspect of the functioning of the body has a cause in the material world. According to this model, the effect of mind and emotion on the body is unimportant. Vimal Patel, of the Department of Pathology and Laboratory Medicine at Indiana University, says that conventional medicine’s narrow Newtonian base has limited its

⁵⁷Fulder refers to two American physicists who claim that homeopathic remedies do not transmit chemicals but information. High potencies (the highly diluted remedies) “may be acting at a subtle level on the subtle energy body rather than the physical body. It may be that at high potencies homeopathy takes off into this realm of healing...” (Fulder, 1996, 202).

ability to understand illness in a more holistic way. It is inconsistent, Patel says, “with the emerging field of psychoneuroimmunology” (Patel, 1998, 53). In the Newtonian universe, the observer is independent of the observed. This belief affects the way in which conventional medical treatment and research is conducted because it assumes that therapy applied correctly is independent of the physician providing the cure and that research results are independent of the involvement of the researcher. The Newtonian world is one of extreme objectivity. Yet modern physics demonstrated in the early part of the twentieth century that the observer is integral to that which she observes and that “every measurement disturbs the thing that is measured” (Patel, 53, 55).

Franz Anton Mesmer (1734-1815) had proposed that an invisible fluid existed between ether and matter which joined the material and the spiritual world (Mesmer, 1799/1980, 119, 121). In the nineteenth century, Newtonian physicists took a look at Mesmer’s “invisible fluid” and proposed that all space and objects were filled with it. They believed that this “luminiferous ether” was the medium that transmitted light waves. Albanese says that “it seemed, in short, the invisible glue that held the world together.” Early in the nineteenth century, Thomas Young had shown, using a double-slit machine, that light was a wave. By 1870, physicist James Clerk Maxwell proposed that light “was the combination of oscillating fields of electricity and magnetism” -- “an electromagnetic wave theory of light.” In 1900, the German scientist Max Planck proposed the theory that atoms emit energy in discrete amounts rather than in continuous waves. He named the energy *quanta*. In 1905, Albert Einstein made a more radical proposal: that light seemed to be made up of small amounts of energy and that this “...radiant energy was composed of separate speeding and colliding particles”(Albanese, 1992, 72). Thus was the new physics born.

The visible universe came to be seen as far less solid than originally supposed. Light could

act like a wave or like particles. Matter became energy that could reshape itself as was proven later by mass accelerators. Along with Einstein's theory of relativity the discovery of quantum energy invited scientists to value probability, not certainty, because the way in which matter transformed itself could not be predicted. Werner Heisenberg, in 1927, coined the term "the uncertainty principle" to describe the idea that one could not sharply distinguish the objective universe from the person observing it. Whatever the researcher did could change the experiment's outcome (see Albanese, 1992, 72-73). In Albanese's words, "some physicists found the new cosmology an occasion for metaphysics" (Albanese, 1992, 73). With quantum physics, according to Albanese:

the stage was set for a latter-day synthesis that would make the past its prologue to a dawning millennium. In this synthesis, the blurring of matter and energy at the subatomic level would be linked in principle to the occult romanticism of the mesmeric-Swedenborgian habit of mind (Albanese, 1992, 73).

Each century expresses its ideas about healing and illness according to the technology of the time. The Victorians were entranced by electricity, discovered in that era. Magnetism became an important concept. The twentieth century discovered quantum physics. Much of the modern literature on healing uses the imagery of the quantum to express the idea of invisible and undefinable energies. Catherine L. Albanese sees the quantum as a "metaphorical sign" -- a magical staff (an allusion to the nineteenth century healer Andrew Jackson) which balances light (Albanese, 1992, 75). Richard Gerber, MD.'s book *Vibrational Medicine* and Deepak Chopra, MD's *Quantum Healing* both promote Einsteinian paradigms of healing which the authors believe will replace a Newtonian one.

Einstein's theory of relativity, along with quantum theory, has been appropriated by the complementary and alternative medical movement because the universe described appears to be non-dual. Observer and observed are one. The physicist Neils Bohr developed, in 1927

what is called the complementarity principle which states that opposites, such as wave and particle, can be complementary (this was a way of expressing the contradictory discovery that light was both a particle and a wave). To see matter and consciousness as complementary, though they are opposites, is, according to Patel, an application of his theory (Patel, 1998, 54). ⁵⁸ Patel cites D. Thomsen who interviewed George Wald, 1967 winner of the Nobel prize for physiology or medicine, in 1983:

...Objection will be raised by those who want to insist that a material universe is all the reality there is. Materialism of this kind is a doctrine that anyone may choose as a working hypothesis or as a religion, but I am unaware of a proof of it. On the contrary, the scientific method, which was designed on a basis of materialism in a deliberate attempt to exclude nonmaterial considerations, has led to other prominent scientists from Newton and Galileo on down to conclude that there were problems rooted in science but unassimilable as science (Thomsen, 1983, cited in Patel, 1998, 54).

New Age groups have eagerly seized quantum theory to their own ends. Robert Ellwood has described New Age connections with Swedenborgianism, Mesmerism and, further back, Neoplatonism (Ellwood, 1989/1992, 59-60). These ideas, reformulated in the language of the new physics, are communicated through various alternative healing centres and publications. Albanese describes the New Age as “a new healing religion” which “has emerged, in good measure, under the metaphorical sign of the quantum” (Albanese, 1992, 75).

Albanese points to two physicians who make liberal use of quantum theory to support a more mystical medicine: Richard Gerber and Deepak Chopra.

Richard Gerber claims that science validates older mystical beliefs that held that the creation

⁵⁸The Einstein-Podolsky-Rosen paradox describes “nonlocal interactions between particles...which cannot be connected by signals moving even with the velocity of light...”. Later physicists described what is called the Bose-Einstein condensate in which “several thousand atoms exist in a state of maximum coherence.” This would be impossible if the universe were as described by Newton (Patel, 1998, 53).

and creatures are beings of light (Albanese, 1992, 75). Gerber sees the Einsteinian paradigm as an extension of the Newtonian one. All matter is energy, as quantum physics shows. "Einsteinian medicine...tries to put the Newtonian picture of biomachinery into the perspective of dynamic interactive energy systems" (Gerber, 1988, 34). In the Newtonian universe, "the world is an intricate mechanism" and the body is "a type of grand machine which is controlled by the brain and peripheral nervous system" (Gerber, 39). The drug therapy of modern medicine is based on a Newtonian belief that manmade drugs, administered in precise doses, will achieve their intended ends. While this method of pharmacotherapy allows doctors to be sure of how a drug will behave, Gerber believes that when herbal remedies are used as drug therapies, important healing components are ignored. Einsteinian medicine "sees human beings as networks of complex energy fields that interface with physical/cellular systems" (Gerber, 71, 39).

Gerber attacks modern medicine for its over-reliance on the Newtonian model. Newtonian mechanisms focus on "structural hardware". If the "heart is a mechanical pump" and the kidneys a filtration system, then they can be replaced mechanically. Gerber has no argument with the advances which help those with cardiac or renal failure to live longer lives. However, he says, "the Newtonian mechanistic viewpoint of life is only an approximation of reality. Pharmacologic and surgical approaches are incomplete because they ignore the vital forces which animate and breathe life into the biomachinery of living systems." Unfortunately, he says, "this animating life-force is an energy which is currently unaddressed by today's Newtonian mechanistic thinkers, whose opinions predominate [in] orthodox medicine." Physicians do not discuss them "because there are no currently acceptable scientific models which explain their existence and function" (Gerber, 1988, 40-41).

However, the current interest in experimenting to prove that prayer “works”, or that religious faith is good preventive medicine, is part of a movement to lend scientific respectability and acceptance to ancient beliefs (see Byrd, 1988; Matthews, 1998; Harris, et al., 1999; Stannard, 1999; Dossey, 1999).⁵⁹ It would seem that some physicians are willing to discuss invisible powers or energies but the power that they are examining is that which flows from prayer and conventional religious belief. The title of Dale Matthew, MD’s book is evocative: *The Faith Factor: Proof of the Healing Power of Prayer*. The growing interest of conventional medicine in researching the treatments of alternative medicine is also part of this movement. Nonetheless, the gulf between conventional and alternative modes of thinking is difficult to bridge. The very title of Gerber’s book, *Vibrational Medicine*, is unlikely to appeal to the scientifically-minded medical specialist. Gerber traces the gulf between conventional and alternative medicine to the split between religion and science which he claims took place thousands of years ago. This is a sweeping and largely incorrect statement. The medical thinkers of the Enlightenment were not, as a rule, atheists. Gerber claims that scientists were trying to take the physical body “out of the realm of the divine and into the mechanistic world they could understand and manipulate” (Gerber, 41-42). But this does not mean they denied religion; it means they confined their work to what was manageable.

Albanese sees Gerber’s use of quantum theory as one which “fuses and conflates”:

Behind Gerber stand the long mystical and metaphysical traditions of West and East with their mutual fascination with the spiritual power of light. Behind him, too, stands the American

⁵⁹Physicist Russell Stannard says experiments studying the efficacy of prayer are an opportunity to see how prayer functions in small-scale, replicable studies. He emphasizes that they do not and are not meant to prove God’s existence but might prove the capacity of humans to project their thoughts. He points out that no scientist assumes that people are not being prayed for by friends and relatives. These studies are trying to measure if additional prayer confers additional benefits (Stannard, 1999, 3, 5, 6).

theosophical tradition with its language of astral and etheric bodies. And behind him, finally, stands the mesmeric-Swedenborgian mentality of nineteenth-century spiritualism with its linkage of spirit to matter and mind to physical substance. Thus, the quantum Gerber appropriates has passed through the prism of religious teaching, and it emerges as refracted in sacred ways. Moreover, the quantum Gerber appropriates combines the law of harmony with the law of active manipulation. While bodies should “vibrate” in accord with cosmic laws and resonate to universal natural forces, active intervention to make nature more natural is not ruled out. Harmony, in short, may be helped (Albanese, 1992, 76).

Deepak Chopra, MD, who once taught at Tufts and Boston University Schools of Medicine and is now a popular proponent of Ayurvedic medicine and a writer and speaker in the holistic health movement, sees the discovery of the quantum as a way in which humans can free themselves from the limitations of time. That “beyond the quantum, your body exists as pure creative potential.” “In the quantum world,” he says, aging is not inevitable (Chopra, 1993, 30, 44, 25).

Believers in esoteric alternatives tend, while rejecting science, to appropriate scientific language and concepts to their own ends. As physicist Robert Park points out, Chopra uses quantum theory in such a way as to imply that modern science accepts Ayurvedic medicine (Park, 2000, 208). Hence the quantum has been used to reinterpret much older concepts. According to Albanese, Reiki practitioners (and many other alternative healing practitioners), “echo the harmonial vocabulary of nineteenth-century magnetic healing” when they speak of harmonizing the energies of the body (Albanese, 1992, 79). Reiki master Barbara Weber Ray speaks of light uniting “Science and Spirit” (Ray, 1992, 199). Albanese says that “under the sign of Einstein’s energy-matter equation ($E=MC^2$), Ray finds light and matter ‘interchangeable’ with light appearing to be ‘at the heart of all things.’” (Albanese, 79). Other types of harmonial healing have similarly been reinterpreted. Crystal healing, the Bach flower healing system, healing with gemstones and homeopathy are all described by Albanese, who alludes to Fuller’s analysis, as systems that claim to heal by attuning “matter and energy, products of a quantum consciousness

appropriated through the same inherited metaphysical world that nourished Andrew Jackson Davis [a nineteenth century physician and harmonial philosopher]" (Albanese, 79- 80).

Proponents of energy healing, when they attack what they describe as the Newtonian universe, are reifying Newtonian ideas as a symbol. All that is soul-destroying, mechanistic and objectively rational is held to be responsible for what they view as the triumph of technology over the spirit. But as Larry Dossey points out, even if modern hospitals incorporate psychological and spiritual understandings of illness into their treatment plans, we cannot get along without Newtonian science or medicine (what he calls Era 1 medicine. See Dossey, 1999). Without it, we would not have heart transplants, microsurgery, hemodialysis or drugs to cure serious or fatal diseases. What distinguishes classical physics from the modern theories of relativity and quantum mechanics is its absolutist beliefs. Modern physics is cautious in its claims; classical physics claimed to be infallible (Holroyd, 1989, 38-39). One suspects that some of the attacks on the Newtonian, mechanistic world of orthodox medicine may be inspired by a strong New Age aversion to earlier, absolute claims.

C. Both/And: Universal Consciousness and New Age Belief

Holistic health movements abhor dualism. Just as New Age beliefs tend to fuse the Creator and creation, New Age believers in holism tend to collapse the dualities of man and nature and reject Cartesian dualism (as well as Christian asceticism) (Hanegraaff, 1998, 119). The observer and the observed are fused and, as noted above, quantum theory is often appropriated to support this position. Twentieth-century New Age movements typically reject duality and the Christian doctrine of original sin. The idea of separation from God is

inimical to much New Age thought and the goal of meditation is to merge with the divine.⁶⁰

In this theology, God is not separate from his creation. This is what Larry Dossey calls both/and thinking. The concept is fundamental to his theory that Era III medicine is complementary to Era I and Era II medicine although it could be well-explained without it (Dossey, 1999, 32).⁶¹

Mel D. Faber, in a fierce attack on New Age thought, points to the tendency to draw sweeping conclusions from scientific theory when he critiques physician-healer Richard Moss, MD. Moss claims that “all human beings can be seen to be united in a continuum of consciousness” and that “modern physics is drawing us toward an understanding of this” (Moss, *The I that is we* 1985, 163, in Faber, 1996, 239). Faber’s thesis, which is based on psychoanalytic theory, is that much New Age thought is based on a refusal to accept separation from the “unconditional love” and feelings of fusion experienced by infants with their mothers (Faber, 243). In a somewhat reductionist critique, Faber sees New Age thought and healing movements as an exercise in infantile omnipotence in which the naturally egocentric infant believes it has unlimited power over its caregiver. He describes what is popularly known as “the urge to merge” as the

urge to *fuse regressively* with the environment, to attach oneself to the surrounding world (universe) in a way that denies, erases, cancels out the ever-present sense of *separation* which the chronologically mature individual must cope with during the course of his days on the planet;...the

⁶⁰The Hindu concept of *Advaita* (non-duality) is understood at a very profound spiritual level. Shirley Du Boulay describes it as an uncommon experience (Du Boulay, 2001, April 21, 575).

⁶¹Dossey is aware that some believers reject the idea of a universal consciousness but he likens it to the Christian doctrine of the Trinity, in which three persons exist in one being. The Swedenborgian roots of Dossey’s thinking are evident not only in his beliefs but in his statement that Swedenborg’s “spirit hovered” over the 1997 Harvard Conference *Intercessory Prayer and Distant Healing Intention: Clinical and Laboratory Research* (Dossey, 1999, 37-38)

longing for *narcissistic inflation*, the longing to go about in the belief that one is somehow magical, wonderful, unique, *radiating* special qualities and energies, as opposed to being simply another regular person in the world (Faber, 1996, 7-8).

New Age beliefs usually attribute dualism to the Judeao-Christian origins of Western society and the “Cartesian/Newtonian” inheritance of the Enlightenment (Hanegraaff, 119; 323). As we have seen, writers in this field point with triumph to what they see as a dawning new age in which an Einsteinian paradigm is beginning to replace the dualistic and mechanistic inheritance of modern medicine. This view is part of a larger New Age belief, with strong theosophical roots, that human understanding is evolutionary. Believers hold that we are on the brink of an age in which a sufficiently critical mass of humans will become enlightened. Original sin has no place in this system. Gerber quotes the statement ‘as above; so below’ and suggests that “when individuals change, the whole planetary consciousness also evolves”(Gerber, 1988, 467).

D. Esotericism

Deepak Chopra and other popular writers in the alternative medical field place their theories in the framework of modern physics, as we have seen. Yet echoes of sixteenth-century esotericism weave through the writings of Chopra and Gerber.⁶² The terms “Esotericism” and “occultism” are often used interchangeably. Hanegraaff sees occultism as “a specific development within esotericism” (Hanegraaff, 1998, 385). He relies on the work of Anton

⁶² The term “esoteric”, used as an adjective, is credited to Aristotle but was first used around 166 C.E. by Lucian of Samosata. The term “esotericism” is more recent and was made popular by the occultist Eliphas Lévi after 1856. Lévi was probably inspired by Cornelius Agrippa’s *De Occulta Philosophia* (16th century) to introduce the term occultism (Hanegraaff, 1998, 384-385).

Faivre to trace the origin of Western esotericism back to antiquity⁶³.

Hanegraaff describes the main components of Western esotericism since the fifteenth century as including (1) neoplatonism and hermeticism; (2) the “traditional sciences” astrology, magia and alchemy (3) theosophy in the form of Christian interest in kabbalah (Hanegraaff, 1998, 387-388). For the purpose of understanding their links to modern complementary and alternative medicine, the following list includes components of Western esotericism such as the doctrine of signatures and correspondences; gnosticism; occultism as a development of esotericism; romanticism and nineteenth-century theosophy. All of these concepts are central to understanding many forms of alternative healing.

Western Esotericism and:

1. Neoplatonism and Hermeticism

Some concepts that lie behind various energy-based alternative therapies have their roots in neoplatonism. Most notable is the belief in a “subtle body” that mediates between the actual, physical body and the higher or purer self. This idea derives from a neoplatonic belief in “subtle matter”⁶⁴ (and the idea that one had an “astral” body) and was

⁶³Faivre points to several developments: in the twelfth century, mechanical arts were developed “that entailed a ‘mechanization’ of the image of the world” (Faivre, 1986, cited in Hanegraaff, 1998, 386). Nature was discovered “as an organic and lawful domain worthy of attention in its own right” (Hanegraaff, 386). In the fourteenth century, the Islamic physician and scholar Averroës proposed an Aristotelian cosmology which called into question the cosmology of the early neoplatonists. The bond between the intermediate angelic realms and the earthly were shattered. This made it easier for scientists of a later age to turn their attention to discoveries in the mechanical and natural world. As Hanegraaff points out, the destruction of the platonic cosmos led to Platonism becoming split off from mainstream thought. The fifteenth and sixteenth century humanists resurrected the ideas of the early platonists but Renaissance neoplatonism was the preserve of esoteric scholars. Hanegraaff marks this period as the beginning of esotericism in the West (Hanegraaff, 387).

⁶⁴Neoplatonists value matter or flesh; gnostics, who are dualists, reject it.

extensively elaborated by modern theosophy (Hanegraaff, 1998, 221, 223, 433, 486). Some therapeutic touch practitioners claim to work on the “subtle” body as they “smooth out” invisible energies and Reiki practitioners believe in the “etheric”, or spiritual body. Sometimes the idea of the aura (a ring of light visible to certain healers) is conflated with the idea of the subtle body. Rudolph Steiner, who founded Anthroposophy in the early twentieth century, believed in an “etheric” body which contributed life, growth and form to humans, animals and plants. He attributed to humans and animals an “astral” body. Steiner was a scientist who founded a branch of alternative medicine -- anthroposophical medicine - - which also sells medicines under the Weleda brand. Only doctors may practice anthroposophical medicine (Woodham and Peters, 1997, 107, 124).

Neoplatonism was a movement extremely important to the esoteric tradition. It began after the death of Plato in 347 BCE. Renaissance neoplatonism began with Marsilio Ficino's fourteenth century academy in Florence. Ficino was opposed to the aristotelian/averroist mechanistic conception of the universe. Neoplatonists believed in a doctrine of universal harmony in which earthly reality reflects the celestial one. That which occurred in the heavens directly affected activities on earth. For the neoplatonist, the universe was an ordered cosmos and all parts were interdependent. The early neoplatonist cosmology described the universe as made up of the celestial realms, the intellectual (angelic) realms and the terrestrial (natural or elemental). Each realm is influenced by the one above it (Yates, 1979, 44). The Aristotelian universe, in contrast, was mechanistic.

Hermeticism was a philosophy made popular by a work translated from the Greek by Ficino. The *Corpus Hermeticum*, which arrived in Florence from Macedonia about 1460, was widely believed to have been written by Hermes Trismegistus, a mythical Egyptian sage supposedly contemporary with Moses. The Hermetic texts were invested with a sanctity

almost equal to the biblical texts of Moses. Important to the esoteric tradition was the belief in a perennial philosophy⁶⁵, deriving from Hermes Trismegistus and Zoroaster and leading up to Plato. Neoplatonists believed that this perennial wisdom had been hidden through the ages, to be revealed only to certain adepts. By 1614, Isaac Casaubon demonstrated that these hermetic writings could not have been written before the beginning of Christianity and modern critics usually believe that the *Corpus Hermeticum* was written between the first and third centuries C.E. Hanegraaff maintains that, though later Hermeticists ignored Casaubon's criticisms, in the long run his work led to Renaissance Neoplatonism's loss of credibility and its eventual irrelevance in serious intellectual circles (Hanegraaff, 1988, 391). It survived in the hermetic beliefs central to nineteenth century theosophy.

Hermeticism in the Renaissance, according to Hanegraaff, is a type of religious syncretism in which scholars attempted to create "a new cosmology" that would unite discoveries in the natural world while acknowledging the importance of the sacred (Hanegraaff, 1998, 396-397). Religious beliefs and scientific discoveries have, at many points in history, coexisted uneasily. Nineteenth-century alternative spiritual and healing movements (like Christian Science) reveal a similar preoccupation with acknowledging the progress of science without sacrificing the sacred. Twenty- and twenty-first century conventional medicine regulates sacred practices by testing them in clinical trials.

The *Corpus Hermeticum* was hugely influential. Its most important contribution to Western esotericism was its "emphasis on intuitive *gnosis* and a positive attitude towards the cosmos

⁶⁵*Philosophia Perennis* was Leibniz' term, later used by Aldous Huxley. It describes a religion with no doctrine which offers the "time-honoured and quintessential wisdom or knowledge vouchsafed by the religious experience." This philosophy is found in modern movements such as Transpersonal Psychology and its ideas in the works of theoretical physicists David Bohm and Fritjof Capra (Holroyd, 1989, 97-98).

and to man's role in it" (Hanegraaff, 1998, 391).

2. Neoplatonism, and the Doctrine of Signatures and Correspondences

The belief in a real or symbolic correspondence between the elements of the celestial, angelic, and earthly realms, as noted before, is an essential element of the doctrine of neoplatonism in which that which occurs in the heavens is mirrored on earth. In the neoplatonic universe, everything is a sign and mysterious secrets can be interpreted by those initiated into this lore. Correspondences may exist between the visible and invisible worlds; between the stars and the human body; between the cosmos and revealed texts such as scripture (Hanegraaff, 1998, 398). Related to the doctrine of correspondences is the doctrine of signatures. This ancient doctrine proposes that all plants reveal their healing properties in their morphology. Nature is alive with wisdom. Paracelsus was the most famous sixteenth-century proponent of this idea. Hence the colour or shape of a plant indicates how it is to be used. Lungwort, which is spotted, was considered to look like a diseased lung and was used to treat pulmonary ailments. Plants that managed to grow in and between rocks were used in the hope that they could break up bladder stones (Crellin, published in Porter, 1997b, 70). Some modern herbalists are guided by the doctrine of signatures.

The idea that the cosmos is penetrated by spiritual forces is central to neoplatonic esotericism. Those skilled in descrying these invisible forces are able to mediate between earthly and heavenly realms through theurgical rituals, incantations, calling down mediating spirits such as angels. Those who hold esoteric beliefs follow an arduous mystical path designed to lead to hidden knowledge of the divine and of the universe (Hanegraaff, 1998, 398-399). This "experience of transmutation", most notably in alchemical experiments, yields secret knowledge (gnosis) which, implicitly, is only available to initiates.

3. Neoplatonism and magic, astrology and alchemy

Marsilio Ficini⁶⁶ and Cornelius Agrippa were two Renaissance neoplatonists who appropriated magic to Christian use. Believing the *Corpus Hermeticum* to be both antique and of divine origin, they accepted its legitimation of “occult sciences”. *Magia* was separated into a dark side, which involved pacts with the devil, and *magia naturalis*, which was a type of natural science. Natural magic, of which astrology is a part, uses occult powers which are supposedly present in nature and is an early form of science. Esoteric magic uses theurgical acts: calling down the spirits; pronouncing the names of numinous beings; engaging in ritual incantations so as to connect with the world of the spirit (Faivre, 1986, 66, cited in Hanegraaff, 1998, 393). It should be noted that as far back as the fifth century, Augustine, who condemned magic, did not include what later became known as natural magic which attempted to discern the meanings behind the wonders (marvels) of natural objects such as stones and crystals (Augustine, Bettenson Trans., 1972 and 1984, Book XXI, 974-979 and see Kieckhefer, 1989, 38-39).

Hanegraaff suggests that magic cannot easily be distinguished from astrology in the Renaissance. Esotericism in this period focuses on the figure of the *magus*. Influenced by the writings of the *magus* Hermes Trismegistus, Cornelius Agrippa, Giordano Bruno and John Dee engaged in rituals which attempted to conjure up angelic beings, supposedly drawing them down from the celestial world. Conjuring angels was considered to be safe compared to conjuring demons. Conjuring was performed through links such as incantations and other acts described above (Yates, 1964, 82, 264-265). Hanegraaff sees the elite magic of this period as a direct precursor of nineteenth century occult rituals and

⁶⁶Ficino wrote an early self-help treatise, *On making your life agree with the heavens (De vita coelitus comparanda)* (Hanegraaff, 1988, footnote, 393).

twentieth century New Age Neopaganism. This is magic as a worldview, not a practice. He says that “the ‘magical worldview’ of Renaissance esotericism is also the model par excellence for the ‘re-enchantment of the world’ that provides orientation to the New Age quest for a new paradigm” (Hanegraaff, 1998, 394).

Astrology, Hanegraaff says, is implicit in the idea of *magia* (Hanegraaff, 1998, 394).

Astrology is the most ancient of sciences and has been used for over four thousand years to divine the future, interpret character and, until the seventeenth century, it was considered to be part of natural science and was used to make medical diagnoses. Astrology is used in alternative medicine to diagnose and predict illness.

Astrology had been used for healing for centuries and was part of orthodox medicine. Historian Nancy Siraisi says that astrology was probably more important in medical education in the fourteenth than the thirteenth century and it was important up to the sixteenth century, possibly due both to outbreaks of plague and to the increasing sophistication of academic medicine (Siraisi, 1990, 189). It certainly enjoyed a revival with the sixteenth century neoplatonic hermetic movement. Astrology and divination were, at this time, important pursuits of intellectuals. The use of the Sphere of Pythagoras (also known as Plato’s Sphere) guided doctors in diagnosis and cure. Using a complex numerological system, in which the letters of patients’ names were given specific numbers and were then arranged in the circle, doctors would determine whether the patients would live or succumb to their illnesses. For example, if the numbers fell below the line intersecting the circle horizontally, it meant the patient would die (Grattan and Singer, 1952, 41-42; Thomas, 1971, 283-284). Thomas points out that William Warde, later a Cambridge Professor of Physic, translated from French the *Arcandam*, a book which taught this system. Seven editions were produced between 1562 and 1637 (Thomas, 283). In the sixteenth century,

Melanchthon encouraged the application of astrology to medicine in the University of Wittenberg's Lutheran faculty of medicine. He promoted astrology as part of natural philosophy which was consistent with the Lutheran conception of God's providence (His providence is knowable through the natural world) in contrast to Calvin's doctrine of providence which was opposed to natural philosophy. Calvin permitted the use of astrology in medicine but, in general, he had nothing but contempt for astrology (Kusakawa, 1993, 37-46). Orthodox Protestants still used astrology in medicine in the seventeenth century.

Physicians also made much use of propitious days. Certain days, for example the dog days, July 14 to September 5 (so named because they fell under the sign of Sirius, "the dog"), were days on which physicians avoided giving a patient remedies as they might be dangerous or fatal (Kieckhefer, 1989, 86-87). Bede, in the seventh century, recounts the story of a nun with a swollen arm. This would not have happened, he said, had she been bled on an auspicious day (Bede, Sherley-Price, Trans., 1955, 268-269). These beliefs were perfectly scientific according to the knowledge of the day.

Alchemy was a hermetic practice in which philosopher-scientists attempted to turn base metal into gold. Sixteenth century alchemists were engaged in a theurgical act in which they attempted to release the "divine element imprisoned in matter (a gnostic belief, see above), to transmute the alchemist's own spiritual substance by ridding it of contaminating impurities and thus enabling the pure soul or spirit to become manifest and free" (Holroyd, 1989, 79). The alchemists' work reflected the neoplatonic gnostic belief that the soul is imprisoned in matter. The alchemists used a pseudo-scientific method to parallel the work of the Kabbalists. Kabbalists assigned elaborate numerological codes (the techniques of this number/letter symbolism are called *gematria*, *notarikon* and *temurah*) to the words of scripture so as to discover its hidden meaning and the true name of God. Alchemists were

attempting the same type of rescue operation. Carl Jung devoted two of his later works to alchemy, relating the alchemical process with psychological individuation.

4. Occultism -- a development of esotericism

Hanegraaff defines occultism “as a category in the study of religions, which comprises *all attempts by esotericists to come to terms with a disenchanted world or, alternatively, by people in general to make sense of esotericism from the perspective of a disenchanted secular world*” (Hanegraaff’s italics). He sees occultism as a “subcategory” of esotericism. Occultism, he says, is “neither a new phenomenon, nor the survival of an old one, but the emergence of a new development in the history of esotericism.” Hanegraaff traces nineteenth century movements such as Spiritualism and Theosophy to this development and rejects the distinctions some make that describe esotericism as theoretical and occultism as practical. To be so personally involved as to practice the occult, one must have extensive knowledge of occult theory (Hanegraaff, 1998, 422). Hanegraaff suggests that “occultism...is essentially an attempt to adapt esotericism to a disenchanted world: a world which no longer harbours a dimension of irreducible mystery... based upon an experience of the sacred as present in the daily world” (Hanegraaff, 1998, 423).

Occultism therefore “*accepts* that world.” “Romanticism”, in contrast

rejects such compromises; it attempts to re-enchant the world and bring back the mystery driven away by the ‘coldness’ of the new science and its attendant worldview (Hanegraaff, 1998, 423).

Hanegraaff sees the nineteenth- century movements Swedenborgianism, Mesmerism and spiritualism as evidence of the way in which esotericism turns into occultism (Hanegraaff, 1998, 423).

Hanegraaff discusses the prevailing belief that “the occult” is “a collection of ‘survivals’; “ ‘the ghosts of old forgotten creeds’ ” (Bateson and Bateson, 1987, in Hanegraaff, 1998, 407). This is a now outdated view inherited from nineteenth century anthropology and fostered by Darwinian evolutionism. As Mary Douglas pointed out, nineteenth century anthropologists saw magic as residual from the evolutionary point of view. This outdated idea of progress saw ancient peoples as rudimentary sketches for the advanced people of the twentieth century (see Douglas, 1966, 7-28). For Hanegraaff, esotericism is not a survival but, like many religions, is a movement which “does not survive unchanged but is continually reinterpreted in the light of new social and cultural circumstances, including those of secular society” (Hanegraaff, 407). He disagrees with Marcello Truzzi, who sees the occult as a “wastebasket” for all those ideas which cannot be proved by modern science or accepted by conventional religions (see Truzzi, 1974, cited in Hanegraaff, 407-408). The occult is not “a recurrent temptation of the human mind” or a “disease of reason” (Hanegraaff, 408) but a movement as worthy of study as any conventional religion.

Occultism has been as deeply affected by secularization as Christian faith. Both have engaged in dialogue with the modern world and reluctantly adjusted to it (Hanegraaff, 1998, 408)

5. Romanticism -- a movement grounded in esotericism

Romanticism is a movement grounded in the esoteric tradition of the eighteenth century but influenced by nineteenth- century evolutionary beliefs (Hanegraaff, 1998, 406). Like the sixteenth century, the nineteenth century was a time of optimism and of great discoveries. Modern appeals to the goodness and purity of natural healing methods draw on Romantic notions.

Romanticism flourished, particularly in Germany, in the latter half of the eighteenth century. According to Isaiah Berlin, the movement represented a significant break with the the world-view of the past because it undermined the belief that objective truth existed and only had to be discovered (Berlin, 1999, 67; Berlin, 2000, 139, 202 and see Berlin, 1979) and introduced an acceptance of a diversity of beliefs and the idea that one could create one's own values (Berlin, 2000, 10, 13). Isaiah Berlin describes Romanticism as a movement driven by "the wish to break up the nature of the given" (Berlin, 1999, 135). The intense rationalism of the Enlightenment era led to a pressure-cooker effect in which individuals looked for an escape from pure reason in movements like Rosicrucianism, Mesmerism, and necromancy. The occult became newly important (Berlin, 1999, 47).

The fundamental character of Romanticism is a sense of nostalgia -- that we have irretrievably lost our home. It reached full expression in the poetry of Byron, in the music of Wagner, in the art of the Pre-Raphaelites. The nostalgia is for an unattainable world that, as Berlin points out, would have been rejected had it become real. The "given" was seen as constricting (Berlin, 1999, 134-136). Romanticism was an exercise in myth-making that could be innocent: the belief in the idea of the Noble Savage, the desire to restore Paradise, the desire to escape the artificial and noxious atmosphere of early modern industrialism. These ideas resonate in twentieth- and twenty-first century New Age and Human Potential healing movements in which technology, and all its pomps and works, is reviled and people are urged to return to that which is natural. But like nature itself, Romanticism had a dark side which spread, like a malignant poison, in the myths of Aryanism which drove the Third Reich (see Berlin, 1999).

If people of the eighteenth and nineteenth centuries felt threatened by industrialization and the increasing alienation of individuals from the sources of life and from each other, how

much more do people of this era view with fear, and even horror, the power of science to erase that which appears human. With the growing ability of science to genetically modify food and alter human genetic structure, this new century may see a strong Romantic impulse to return to nature. The philosopher Charles Taylor speaks of instrumental reason that divides nature into disconnected parts, separating reason and belief and dividing people from themselves and others. He suggests that the struggle between Enlightenment and Romantic ideas continues today (Taylor, 1989, 413). When alternative medicine calls itself holistic, it implies that conventional medicine is fragmentary and divisive. Many alternative medical practices are grounded in the Romantic vision of nature as source and opposed to the Newtonian and Enlightenment belief that the goal of humankind is to study, analyze and subjugate nature. And, just as the Romantics rejected the “given”, some people in the mid-twentieth to early twenty-first century also appear to reject the inexorability of objective reality when they refuse to accept medical explanations and answers for illness, disability or ageing. A promotional pamphlet for a videocassette by Deepak Chopra makes some extravagant claims : a woman with a tumour used her mind to get rid of it; a burn victim told he might lose an eye said “I don’t understand all the fuss. I’m not going to lose my eye...”; a 56-year old (like Dorian Grey) begins to look younger and younger the older she gets (promotional literature from Nightingale Conant, August, 2000).

6. Nineteenth century Theosophy

Healing movements that make extensive use of notions of invisible “energies” or subtle bodies, as well as those that combine this with spiritualism, may unknowingly be borrowing from ideas elaborated by nineteenth-century theosophists. The Theosophical Society was founded in 1875 by Helena Blavatsky, a medium and psychic and Henry Olcott. Theosophy combines Greek and Egyptian mystery religions, Kabbalism, Eastern scriptures and the promise of secret knowledge (Holroyd, 1989, 107).

Like many others in the nineteenth century, theosophists were at pains to emphasize the scientific nature of their work. Col. Henry Olcott, a close associate of Mme Blavatsky, wanted Theosophy to be a science, not a new religion (the name means sacred science)⁶⁷. But Theosophy was hardly objective about what it claimed to study, believing in and even producing the phenomena it claimed to investigate (Washington, 1987, 55). For example, Mme Blavatsky channelled the spirits of the dead.

Blavatsky, who had experimented with the occult, came to believe in a universal brotherhood -- a group of Masters headed by Master Morya and assisted by the Buddha, the Mahachohan, Manu and Maitreya. The Masters included all the spiritual leaders of the past, such as Abraham, Moses, Plato and Jesus. Blavatsky believed that the true doctrines of the Masters were not available to ordinary people because those who tried to spread their message were prevented by the "Dark Forces". Consequently, they work secretly to "direct the destiny of the cosmos" (Washington, 1987, 34-36). *Isis Unveiled* (1877), which Blavatsky claimed was created by the spirits she channeled, begins with an attack on the narrowness of science for focusing only on the material and measurable universe (Washington, 52).

The late nineteenth century was a period of "passionate amateurs and spiritual autodidacts" (Washington, 1987, 53) as well as radically new scientific theories. Very creatively, Blavatsky did not attack science head on but took the new theories of creation and subsumed them "into a grand synthesis that makes religious wisdom not the enemy of scientific knowledge but its final goal" (Washington, 52). *Isis Unveiled* took Darwin's

⁶⁷Jacob Boehme (1575-1624) had used the term to describe his study of the benevolence of God and the presence of evil in the world (Washington, 1987, 54-55; 409).

theory of evolution one step further -- monkeys become men and men “evolve into higher beings” (Washington, 52). -- a thought that endures in New Age belief in a dawning age in which humans will attain a higher consciousness.

* * *

The next and final section of this chapter will serve as a bridge to part four, which will examine complementary and alternative medicine according to the four principles of autonomy, non-maleficence, beneficence and justice. The following will look at ethical issues in the specific context of the religious influences in complementary and alternative medicine.

Ethical Issues and Religious Elements in Complementary and Alternative Medicine

Because complementary and alternative medicine, in some aspects of its practice, is religious or spiritual, it may pose ethical dilemmas not found in other types of medical treatment. The following are some ethical issues as they relate to the four principles of autonomy, non-maleficence, beneficence and justice.

1. Autonomy: implicit spirituality and informed consent -- controversial practices and ethical issues

While many authors refer to complementary and alternative medicine’s religious elements, the topic is usually covered in passing or in one article in an edited book or paper at a conference.

While some consumers may not particularly care if the type of alternative modality they

have chosen is religious, those with clear religious beliefs of their own might want to know if their preferred type of therapy is based on ideas in conflict with their beliefs. Those without religious belief may also find certain doctrines unpalatable. Information about the religious or spiritual content of a technique is part of informed consent. For example, a person consulting a reflexologist was told that the disease supposedly detected by manipulating her foot was probably one experienced in a previous life. A devout Christian, she rejected this interpretation. A Protestant evangelical would be unlikely to accept forms of healing based on channelling spirits of the dead. A number of Christian groups oppose the mind-emptying techniques common to some forms of meditation. A Catholic in a yoga class objected to being asked to bring flowers and offerings to be placed before the statue of the Buddha. Devout Jews and Muslims might also find certain beliefs objectionable. Articles in mainstream works, like one on spiritual healing by Daniel Benor, MD in Jonas and Levin's textbook on complementary and alternative medicine for physicians and health care professionals, often speak of certain religious doctrines as if they were merely accidental to techniques provided by the healer. Benor assumes, for example, belief in reincarnation, channeling of the spirits of the dead, and help from spirit guides. His source for his reference to reincarnation is *Voices from other Lives: reincarnation as a source of healing*, by T. Dethlefsen (1977). For healing through the spirits of the dead, he refers to Barbara Brennan's *Light Emerging* (1993) (Benor, 1999, 374). He also recommends Barbara Brennan's school of healing as one of the best for certification as a spiritual healer (Benor, 379).

Because many Christians and Jews reject all forms of occultism, it would be important for them to know if their Reiki practitioner or Therapeutic Touch practitioner planned to channel a spirit guide in an attempt to heal. The Catholic Church rejects all forms of occultism, including divination and spiritualism (Catechism of the Catholic Church, 1994,

2115-2117). In interviewing healers who are applying to work in hospitals, important questions to ask at an interview would include: does your form of healing include the channelling of spirit guides or other deceased people? Do you suggest to patients/clients that present problems have their roots in past lives? These questions should be asked not to reject the applicant but to make sure that consent forms for patients include this information.

Some Christian books on the New Age react with alarm to all forms of alternative medicine, seeing it as an inherently deceptive method of smuggling anti-Christian beliefs into the mainstream. Even those who do not share the concerns of these authors still need to clearly understand the ideas and beliefs that lie behind the type of healing method they plan to use. Many practitioners say “don’t worry; it’s spiritual”, without realizing that this is precisely the problem. Those who believe that all religions are one and that any type of spirituality is automatically positive are unlikely to perceive dangers in the same way as the orthodox (some might say conservative) Christian or Jew who sees some forms of complementary and alternative medicine as a form of neopaganism.⁶⁸

Some controversial practices for Christians might include psychic healing, Reiki and Therapeutic Touch (although a number of Therapeutic Touch and Reiki practitioners do not believe that they are engaged in a spiritual practice and do not channel spirits), occult healing using crystal therapy or divination techniques such as astrology or medical dowsing. Psychic methods are the most problematic and include psychic diagnostic methods and

⁶⁸Carl E. Braaten, writing in *Either/Or: The Gospel or Neopaganism*, says that Neopaganism is a “spiritual religion” with no need for the historic bible or the Church. It is an inward religion in which individuals try to know God by delving into their own psyches. It is a religion of personal spiritual pilgrimages in which the “universal fellowship” (of love) replaces the concrete body of Christ, the Church and “history itself is nothing but a resource of symbols to stimulate certain moods and feelings according to each person’s private fancy” (Braaten, 1995, 19-20).

healing through channelling dead spirits (although the Catholic cult of the saints might seem analogous). They are closer to the paranormal than to conventional religious or medical belief (Osborn, 1992, 17-19; Chandler, 1988, 168-169). Russell Chandler, the religion writer of the Los Angeles Times at the time he wrote *Understanding the New Age*, says that though many types of alternative and complementary techniques offer common-sense advice, they step over the line when the effectiveness of the techniques is ascribed to “some form of mystical, spiritual energy” or are part of a set of beliefs that include reincarnation and pantheism (Chandler, 167-168).

Chandler calls for discernment, which is an important part of informed consent. Many New Age healing books and practices are extremely seductive, promising lightness, wellness and everlasting bliss. A vast publishing empire puts esoteric ideas at the disposal of the general public. Chandler uses, as an example, the *Wellness Workbook* by Regina Sara Ryan and John W. Travis (1981) which initially offers ideas that would benefit most people.

However, when the authors suggest filling a bottle with water and placing it on the window sill to receive the rays of the rising sun, preparing themselves for a ritual of purification, they step beyond common-sense advice into the realm of the spirit. The book suggests that the reader sit with the water the night before, tell it what is needed and then drink it in the morning in an act of ritual cleansing. It suggests to the reader that she take a new name after this morning water ritual. Chandler points out that, in his opinion, at this point, the book moves from health to “the religion of self.” It has, he points out, slipped into the ritual the belief in universal oneness and makes a god of the “higher self”. He believes that the ritual trivializes the sacrament of baptism and ought to be rejected, no matter what one believes (Chandler, 1989, 254-255).

It can be extremely difficult to discern the philosophical and religious ideas underpinning an

ostensibly innocuous practice. Because practices like Therapeutic Touch or Reiki seem so soothing to the patient, and so “spiritual”, they are now practiced freely in the palliative care wards of many hospitals. While not endorsing the inflammatory idea that this is part of an orchestrated conspiracy to wean people away from orthodox, bible-based beliefs, it is important for the consumer (who could be a hospital manager contemplating hiring a complementary medical practitioner) to be aware of what he is buying when seeking out a healing practice. This is why this chapter presented a summary of some of the major ideas underlying the practices and why the last chapter put these ideas into the wider context of the history of healing and medicine.

Physicians who look to the past, in which religion and medicine were closely joined, may be tempted to create a reality that is impossible to realize in the modern, secular world. Some physicians are now attempting to “prove” that religion ought to be incorporated into medicine. Larry Dossey says there are approximately 150 scientific studies of the power of prayer and thoughts to affect healing (Dossey, 1999, 191). For instance, Dr. Randolph C. Byrd conducted a double-blind, randomized trial on prayer as a healing method in a Coronary Care Unit (Byrd, July 1988, 826-29).⁶⁹ This, and other studies, even when they are well-designed, seem to be an attempt to pin down the unmeasurable. One might ask if it is ever possible to use the discourse of modern science to probe and lay bare the mechanisms of prayer. One might even go so far as to suggest that such attempts are an exercise in scientific hubris — a wish to penetrate and control the ephemeral and elusive.

⁶⁹This study has been replicated. For example, Harris and his colleagues improved on the Byrd study by blinding it so completely so that patients and medical staff did not even know of its existence. Controversially, informed consent was not sought (so as to avoid any placebo effect) and patients were not pre-screened to see if they would accept someone praying for them (Harris et al., October 25, 1999, 2273-2278). British physicist Russell Stannard discusses another study that he considers to be an improvement on Byrd's original. This study matches patients so that all undergo the same type of surgery and there is a one- and two- to- three- year follow up (Stannard, 1999, 1-4).

Some physicians now believe that studies on prayer, and the related, but different, studies on the benefits of church-going, mean that they ought to encourage their patients to pray or read the bible (see Matthews, 1998). These physicians may not realize that their spiritual suggestions may be heard by some patients as almost divine commands. This could pose a threat to autonomy.

The laws and ethical norms that govern professional relationships between patient and doctor are secular norms, based on rights of autonomy, non-maleficence, beneficence and justice. A client who seeks out an alternative practitioner to experience a spiritual type of healing will relate to this person very differently than she will to a conventional physician or nurse. What elements of informed consent are necessary if a conventional physician or nurse offers such a practice? What effect will this type of treatment have on the normally distant relationship between conventional caregiver and patient? Will patients find it more difficult to exercise their right to refuse or discontinue treatment?

What of healing in groups? When the involvement is one of discipleship or devotion as a means of access to sacred healing powers, the principle of autonomy may seem difficult to apply. Indeed, one might ask whether sacred movements should be held up to such scrutiny. Catholics and others freely choose to visit shrines such as Lourdes or participate in Charismatic Renewal healing masses. At this point, the choice of a healing method passes into the overtly religious. Unless the religious group breaks the civil law by abducting children or obviously depriving people of their liberty, the state will not step in and bioethicists will hardly be invited to contribute their views. Many such groups function within organized religions that act to control excesses. The focus, therefore, of this section has been on healing between client and practitioner that is ostensibly “medical” but grounded in or influenced by the spiritual.

Linda Gunderson, in a commentary in the Jan 18, 2000 issue of *Annals of Internal Medicine*, discusses the recent interest in studies that suggest that faith, prayer and church-going can improve health and reduce mortality. Some doctors are contemplating introducing religion as an adjunct to medical treatment.⁷⁰ In 1996, *Today Weekend* and *Time* arranged to have surveys conducted to see if patients wanted their doctors to combine religion with medicine. Two-thirds said they wanted physicians to discuss religion with them. Gunderson wonders whether this indicates that patients feel medicine would be less de-personalized if religion were incorporated into standard medical care (Gunderson, 2000, 170-171). This desire may introduce a new set of ethical problems into the medical setting.

2. Beneficence and non-maleficence: benefits and dangers of spiritual interventions in the medical setting

Authors like Larry Dossey believe that we harm patients by not offering the benefits of non-local healing -- prayer and other spiritual healing techniques (see Dossey, 1999). David Hufford, in comments made at the conference *Complementary and Alternative Medicine in the Academic Medical Center: Issues in Ethics and Policy* (November 10, 1999) said he believes that an important ethical aspect of the use of complementary and alternative practices in the hospital setting lies in the importance of respecting the beliefs of staff and recognizing and honouring cultural diversity. He pointed to the dangers of ignoring the spiritual dimension.

However, Hufford recommends caution in making spiritual interventions in the medical setting. In his view, spiritual interventions need not be integrated into the hospital setting.

⁷⁰For instance, a study at Duke University concludes that church-going is beneficial to health (J Gerontol A Biol Sci Med Sci., 1999; 54: M370-6, cited in Gunderson, 2000, 169).

Even when research shows evidence of the medical effectiveness of spiritually-based practices in culturally pluralistic settings, it would be harmful and unethical, he says, to impose them. He points out that a number of people have, for example, religious scruples about certain practices. Meditation is one example because some fear that the devil can enter the emptied mind. When religiously diverse cultural traditions are applied as a series of remedies, “we [can] seriously misunderstand [how to use them]”, he said. If one attempts to apply spiritual practices with little training, harm can result (Hufford, *Complementary and Alternative Medicine in the Academic Medical Center: Issues in Ethics and Policy*, November 10, 1999).

Gunderson comments that while authors like Dale Matthews (*The Faith Factor*) feel that religion and medicine should be fused, others believe that doing so leads physicians to go beyond their area of expertise, wasting time that could profitably be spent on the patient’s specific medical needs. She adds that mixing religious belief and medical care in a physicians’ practice may be “downright unethical, as physicians may unduly influence a patient’s beliefs” (Gunderson, 2000, 171). A special ethical problem arises when physicians prescribe bible reading and prayer.⁷¹ Richard Sloan, writing in *The Lancet* (1999; 353: 664-667), believes that physicians should no more prescribe religious practices than give their patients advice on how to manage their finances (Sloan in Gunderson, 171). In an article in the *New England Journal of Medicine*, he and his co-authors argue that such practices are intrusive, coercive and in danger of trivializing religion (Sloan et al., 2000, June 22, 1914-1915).

⁷¹Dale Matthews, MD opens his book, *The Faith Factor*, with the suggestion that a physician can now recommend religious interventions based on scientific studies published in major medical journals (Matthew, 1998, 15-16). He describes a seriously ill patient for whom he recommended bible reading (Matthews, 64-66).

Other harms are noted by Larry Dossey. If we believe, based on scientific studies, that thoughts and prayers can heal, then the corollary is true: they can harm (Dossey, 1993, 145-158; Dossey, 1999, 155). Diabetics have been reported to have gone into insulin shock during a healing session. Benor recommends that patients tell their doctors if they intend to engage in practices like these because they may need a lower dose of medication (Benor, 1999, 378).

3. Justice and the commodification of spirituality

One must ask whose interests are being served when complementary and alternative medicine with a spiritual component is promoted in the hospital setting. Offering complementary medicine may seem like a “value-added” benefit. But it may be offered for a fee. While patients might be happy to pay a fee for a service that they hope will relieve pain and/or enhance healing, the hospital may be using it as a way to generate profit. When patients are asked to pay for a treatment in a system that is largely state-funded, hospital administrators should carefully examine each technique for safety and efficacy before offering it. Many may see prayer and spiritual techniques as harmless. However, they should carefully examine each technique proposed and rigorously interview practitioners applying to practice in the hospital. Just as New Age spiritualities have been slipped into the workplace under the guise of employee empowerment workshops, so too can these beliefs intrude into what is presented as a mere treatment technique. One palliative care manager said that she had great difficulty determining which of the alternative medicine applicants she interviewed had proper training. The spiritual biases of interviewees is not always apparent (personal communication, palliative care manager, February 2000).

At the Philadelphia conference on *Complementary and Alternative Medicine in the Academic Medical Center: Issues in ethics and policy*, Dr. Ted Kaptchuk spoke of the

bankruptcy of spirituality in the rush for market share. He believes that offering massage, herbal remedies and other techniques to soothe the spirit is a peculiar use of spirituality. We are creating a spiritual shopping mall, he said, in which religion is reduced to a healing item on sale. He sees the interest of conventional medicine in spiritually based practices as “a way to patch up what they have lost.” “We are all uncertain and no religion saves us from the torment of being human. The rush to integrative medicine may leave us worse than we began” (Kaptchuk, lecture, *Complementary and Alternative Medicine in the Academic Medical Center: Issues in Ethics and Policy*, November 10, 1999).

The interest in returning medicine to its religious roots is a recent trend that may raise unexpectedly troubling issues. No one argues that religion does not have a place in health care, otherwise why would hospitals ensure that patients have access to chaplains, chapels and religious services? But to mix medicine and religion in the fashion suggested by Dossey or Matthews may compromise the patient’s freedom of religion.

Religious communities, Catholic, Protestant and Jewish, founded hospitals open to all but imbued with the ethos of a specific religion or denomination. In a Catholic hospital, for example, patients might hope that doctors and nurses share their beliefs and customs and even pray for them. In recent years, hospitals of religious foundation have become religious in name only, becoming secular institutions that offer religious services on request. The founders of religious hospitals had a clear healing mission rooted in the religious perspective of a particular group and religion was an integral part of the institution. With secularization, religion is offered on the same basis as counselling services by clergy and specially mandated laypeople who may be seen as a type of spiritual social worker -- trained in listening and problem solving but with a spiritual approach. Clergy who gave spiritual advice in the past for no remuneration have become licenced professionals who are paid

hospital salaries and, when with individual clients, hourly fees.

In a hospital, the patient is divided into discrete sections: the surgeon cuts out the tumour but visits the patient only once, and briefly, before she is returned to the world outside. The overworked nurse recognizes the patient's fears but has little time so calls on the social worker to deal with worries resulting from illness (perhaps a fear that one's family may not be able to look after the patient at home). The social worker, hearing the patient talk of death, may become alarmed and call in the pastoral service worker. If the patient gets angry and "acts-out" -- a not uncommon response to the diagnosis of a serious illness, the medical resident may suggest that the patient needs a "real" helping professional with medical training -- a psychiatrist -- to deal with what may be noted in the chart as "inappropriate anger". The psychiatrist, uneasy with talk of death and other spiritual matters, may then go back to the beginning and call in the pastoral services professional.

This severing of religious belief, ritual and feeling from other aspects of patient care mirrors the Cartesian separation of emotion from the body and the detachment of official religion from official medicine.⁷²

Conclusion

Fuller says that, according to psychologist of religion Peter Homans, "the Protestant denominations that have so influenced American religious life emerged in Western culture precisely because of their ability to meet...[a] fundamental 'prerequisite' of psychological,

⁷²Some medical schools have attempted to restore the connection. Students at Harvard Medical School, learn how to obtain a spiritual history and talk about religion to their patients; students at Washington University School of Medicine take courses to explore spiritual issues for themselves and their patients (Gunderson, 2000, 172).

physical, and spiritual vitality.” For some, they are a “kind of cultural successor to classical Protestantism... .” According to Fuller, many modern people find it difficult to “ ‘idealize’ adequately the God of institutional religion ...” They may turn to unorthodox medical systems to “mediate a sense of the sacred.” In this manner religion influences personal rather than public life, which some consider to be evidence of the advanced secularization of society. Physical illness and personal failure force many to consider the existence of a higher being. During dramatic moments of personal grief, loss and tragedy, the perception of religion as trivial may shift to reliance on the divine, in whatever form (Fuller, 1989, 136-137). As Fuller says:

it is to the credit of these metaphysical healing systems that they have enabled many Americans to perceive the religious hypothesis as a living one. Insofar as growing numbers of modern individuals have difficulty maintaining a vital sense of self-love and suffer from emotional impoverishment, questions concerning the psychological accessibility of God are far more fundamental to the emergence of genuine spirituality than are those of instinctual renunciation and moral obedience (Fuller, 1989, 137-138).

The early settlers of America brought with them their belief in a God who selected only a few elect. Believing themselves to be among that divinely anointed group, the Pilgrim Fathers attempted to build a new Jerusalem that would witness to the world the righteousness of God. The descendants of those pilgrims attenuated the image of God as judge and God’s more kindly attributes were called upon to provide solace and healing. Transcendentalists, Mormons and other nineteenth century religious leaders thought they could build a utopia here on earth -- a gentler version of the new Jerusalem envisioned by the Pilgrim Fathers. From the vantage point of the early twenty-first century, religion in North America is far from dead. God exists in the hopes and dreams of much New Age thought and healing practices which are but another form of an old utopian dream.

The twentieth century saw an explosion of healing movements that echoed ideas found in

the traditions of Neoplatonism, esotericism, occultism, romanticism and Theosophy. It is a commonplace that there is little new about the New Age. Books, television shows and traveling healers offer youth, longevity, well-being, escape from stress and misery. Early twenty-first century people are no more immune than their ancestors to promises of relief from pain, suffering, ageing and death. It could be argued, as Fuller does so forcibly, that a secular age is particularly vulnerable to the lures of alternative forms of healing. Hence the importance of paying close attention to spiritual claims and philosophies hidden in what purports to be just another form of medicine.

The spiritual aspects of complementary and alternative medicine may present very specific ethical dilemmas, especially when these practices are introduced into the conventional setting of biomedicine. Biomedicine, like the corporate world, sets great store by attempting to be value neutral. Conventional medicine is not equipped to deal with spiritual issues; religion is seen to lie outside its sphere of interest or influence. When boundaries are crossed -- for example when techniques from alternative religions are introduced into the workplace or the school -- individuals rightly object.

If the current interest in complementary and alternative medicine is a partially disguised attraction to religion, hospitals owe it to their patients to be very clear about what they are offering. When religion "intrudes" into ostensibly value-neutral space, worrying ethical issues arise. In an attempt to be beneficent, hospitals offering energy healing rituals may be unknowingly depriving patients of autonomy and exercising an unintentionally malign influence on their freedom of choice and freedom of religion. Medicine and religion, as this chapter has emphasized, have, in certain historical periods, been inseparable. The Enlightenment severed one from the other and most physicians, even when religiously motivated, leave religion to the chaplains. Current attempts to combine the two may be

laudable but need careful handling.

Section four of the thesis will look in detail at the four bioethical principles that govern the conduct of conventional medicine and see how they apply to diverse forms of healing.

Part Four

Autonomy, Non-Maleficence, Beneficence, Justice and the Practice of Complementary and Alternative Medicine

Part Four - Introduction

Autonomy, Non-Maleficence, Beneficence, Justice and the Practice of Complementary and Alternative Medicine

The next five chapters will examine major ethical issues in the practice of complementary and alternative medicine through the lens of principlism. Chapter seven will look at autonomy and informed consent; chapter eight will examine how the principles of non-maleficence and beneficence apply to safety, efficacy and ethical research in complementary and alternative medicine; chapters nine and ten will extend the principles of non-maleficence and beneficence to encompass the state and professional associations that have an important role to play in protecting the public both in terms of regulation and training and licencing requirements. Chapter eleven will discuss complaint systems and sanctions as an aspect of adjudicatory justice; access and public information under distributive justice and the ethics of complementary and alternative medicine as a business practice under commutative justice.

Some may argue that accountability does not fall neatly into the categories of non-maleficence and beneficence and needs a different ethical principle. But surely the regulation of products, practices and services is part of assuring the good of society (beneficence) and preventing harm (non-maleficence).

The conclusion to the thesis will ask whether the four-principles theory of the *Belmont Report* (elaborated by Beauchamp and Childress) adequately encompasses all the issues in an ethical practice of complementary and alternative medicine or whether unique elements in CAMs require additional principles. This section will look at how the four principles are applied in conventional medical practice.

Chapter Seven

Autonomy, Informed Consent and the Practice of Complementary and Alternative Medicine

Introduction

A psychotherapist suffering from severe hearing problems had to wait a few weeks for the results of tests prescribed by an ear, nose and throat specialist. After friends suggested she try alternative medicine while waiting, she decided to see if it could help.⁷³ She chose a licenced practitioner (she doesn't specify which type) and made an appointment. The encounter seems to have gone badly from the start. When she entered his office he addressed her by her first name (although he knew her professional title) but introduced himself with his professional name. When she explained her ear problem, he asked her to remove shoes and jacket and to stand. "He commented on my pronated feet and said that there is a theory relating pronation to toilet training" she said. He then twisted her body to prepare her for an adjustment. This appears to be a chiropractic or osteopathic technique but it is not clear what this practitioner was licenced to do. The client asked about contraindications. "Yes" he said, there were "more to this form of adjustment than others...[.] He apologized for not bringing it up sooner." The psychotherapist decided not to undergo an adjustment as she could see no connection between this technique and her hearing problem. The practitioner indicated that, once she trusted him, she would be "more

⁷³This client used alternative medicine after receiving conventional diagnostic tests but before she had the results. Though the literature describes patients who wait until test results offer a definitive diagnosis before consulting an alternative (or, more properly when both are used, a complementary) medical practitioner, the behavior of this person is consistent with the way in which alternative/complementary medicine is used -- as an adjunct to conventional diagnosis and treatment. Meredith McGuire discusses this practice in *Ritual Healing in Suburban America* (1988).

relaxed about treatment.”

The practitioner then asked his client to lie on a table, held his hands above her face and asked her to “think back to seven years ago. Did anything come to mind?” The client asked what this was all about. He replied that he was doing “a regression”.

The encounter concluded with the client asking “what about my ear?” and the practitioner writing a prescription for tinctures⁷⁴. She asked about evidence of efficacy. He replied “only anecdotes” but added that “one of the tinctures was especially recommended by his teacher” (Larocque, August 12, 1997, A24).

The consultation breaks down into several steps which reveal serious defects in the practitioner’s attempts to obtain informed consent. After the introduction and the request that the client remove some clothing, the practitioner did the following:⁷⁵

1. commented on her pronated feet and related it to toilet training. Not a word is said about the presenting problem -- hearing difficulties.

⁷⁴Some chiropractors are “mixers”, combining naturopathic or homeopathic treatment with the specialty in which they are trained. One chiropractor, Keath R. Nevison, D.C., of Calgary, Alberta, says that he and his colleagues receive on a regular basis invitations to take short courses in different types of alternative medicine as an inducement to “enhance” their practices. Many chiropractors, like Dr. Nevison, object to this practice as thorough training in one branch of alternative medicine does not translate to expertise in another (Nevison, personal communication, November, 1993). The same, of course, can be said of medical doctors who take short courses in homeopathy.

⁷⁵This example is used simply to illustrate problems with informed consent in an alternative medical setting. It is not meant to imply that alternative practitioners are somehow deficient in honoring the doctrine of informed consent. After all, it is only in the past 30 years that conventional medicine has grappled with all that informed consent entails.

2. prepared his client for a (spinal?) adjustment without any explanations. She asked about contraindications. He said that this technique had more contraindications than others and apologized for not mentioning it first. This is a serious lapse as spinal adjustments can cause strokes if improperly performed. An important element of informed consent is missing here. The practitioner did not explain what he planned to do and did not seek consent for this specific intervention. The client, wisely, objected. The practitioner responded that, once she trusted him more, the client would be more relaxed -- a response both tangential and paternalistic.

3. held his hands over her face (a form of energy balancing?) and asked her to regress back seven years. He did not seek consent for nor explain the reasons for his actions or what he hoped to achieve. The client had to ask. The answer, "a regression", was not illuminating.

4. When the consultation was over, the practitioner scribbled a prescription but the client had to ask "will it work?" The answer is woefully inadequate by the normal standards of informed consent. The practitioner relied on anecdotal evidence and the fact that his teacher believed one of the tinctures was effective. He did not speak of side effects nor give his client any idea of how long it would take for a cure, if any, to be effected.

Several transactions distinguish this encounter from that between a conventional physician and patient. Assuming that the patient has automatically consented to all aspects of the examination because the patient has made and accepted an appointment is not unusual in conventional medicine. However, in conventional medicine, many doctors believe that patients are familiar with such procedures as measuring blood pressure or applying a stethoscope. An intervention as major as a spinal adjustment (though not spelled out in Larocque's article, this seems to be the proposed intervention) needs detailed explanations.

Remembering to explain side effects only after the patient asks for details can also happen in conventional medicine. What most notably appears to distinguish this encounter from that between a medical doctor and patient is the practitioner's request that the client trust solely in his authority right after the client asked about contraindications. One would hope that few modern doctors, aware of the legal and ethical requirements of informed consent, would be so strikingly paternalistic. This practitioner probably knew the client would be unfamiliar with the various procedures he performed. Yet he simply commands the patient to stand or lie down with no explanation about what he intends to do. Furthermore, he had very little scientific evidence to back up his claim that any of his procedures were effective. He needed to rely on the client's trust in himself and another authority -- his teacher. This would probably not be necessary if his procedures, and the tinctures he prescribed, had more than anecdotal evidence to back up their claims of efficacy.

Because complementary and alternative medicine is seen as non-authoritarian, some people suspend skepticism when approaching or being approached by an alternative practitioner. The reasons are several: they have made the choice themselves; they are often not critically ill; the practitioner is able to spend a lot of reassuringly comforting time with them; they feel listened to, and so on. But as the case described illustrates, even alternative practitioners can be very short on clear communication and can be just as paternalistic as some conventional physicians are reputed to be.

Some Special Problems in Obtaining Informed Consent for Complementary and Alternative Medical Practices

Informed consent is a legal and ethical doctrine that grounds all the other requirements of an ethical practice of alternative medicine. Knowledge about the training and competence of the practitioner and the safety and efficacy of treatment proposed is as much a part of

informed consent as the information given to the client about diagnosis, prognosis and proposed treatment, because an effective diagnosis, estimated duration of illness and information about cure and choice of treatment rests on professionally acquired knowledge. If the training is poor, the practitioner is unlikely to be competent or able adequately to present details about risk. The poorly-trained practitioner would be incompetent to make accurate diagnoses or prognoses or assess the efficacy or safety of the treatment.

Some difficulties that may arise in applying the doctrine of informed consent to alternative medicine include: (1) the practitioner and client sharing a belief system; (2) too much disclosure of information (which is now common in conventional practice) robbing the patient of hope; (3) inadequate disclosure of the dangers, explicit or implicit, of spiritual practices. Following are some important questions related to these issues.

1. Shared belief systems

It may be difficult to apply the doctrine of informed consent to a field where patient and practitioner share a belief in the system chosen that may seem more religious than scientific. How does one apply this doctrine to a field where patient and practitioner share a belief in a system with no recognized scientific basis? Many types of religious or spiritual healing attract people desperate for a cure who then become bound to the group and leader in a way that attenuates clear-headed judgement.

2. Information destroying hope

The power of the imagination is such that giving all the information necessary for informed consent may create a negative effect. If the patient is told the prognosis is poor, the information may act as a self-fulfilling prophecy. How can one honour the patient's right to information while still inspiring hope in the face of possibly fatal disease?

3. Inadequate disclosure of the dangers, explicit or implicit, of spiritual practices

If alternative medicine is, as Robert Fuller says, a type of unchurched spirituality (Fuller, 1989), how informed is the potential client about spiritual dangers? Can we say there is such a thing as spiritual danger? Larry Dossey, MD, a popular writer on the power of prayer to heal, claims that prayer is so powerful that it can damage (Dossey, 1993, chapter 9). As practitioners are hardly likely to view their type of healing as dangerous, this sort of information will probably not be imparted. Yet meditation has been known to unhinge not only borderline schizophrenics but others who thought themselves to be emotionally well-grounded (Fugh-Berman, MD., 1997, 167-168). Fugh-Berman looked at a study of long-term meditators. Seventeen of twenty-seven reported at least one adverse effect which included increased alienation from others or disorientation (Shapiro cited in Fugh-Berman, 167). Problems also exist when practitioners who claim to channel invisible energies do not fully disclose to the client other factors, such as their reliance on spirit guides.

Many types of complementary and alternative medicine are grounded in understandings of illness that differ radically from those of conventional medicine. For example, the concept of vital energy is not usual in conventional diagnosis. The patient or client may be unfamiliar with a practice and need extensive explanations. The alternative practitioner, even if his or her understanding of illness and diagnosis is very different from that of conventional medicine, should be able to discuss benefits and risks according to the standards of his own discipline.

Other issues in informed consent include the fact that, at the moment, doctors are under no obligation to discuss alternative treatments that fall outside the boundaries of conventional medicine although lawyer Michael H. Cohen thinks they ought to be (Cohen, 1998, 59-60).

In some cases, they are forbidden by their codes of ethics to do so, as noted in chapter two.

Special consideration needs to be given to people's capacity to consent. Even the mentally competent can find it difficult to express their decisions to their caregivers if they are part of a "vulnerable" or "captive" population. It is generally true that hospitalized patients are more inclined to go along with what is proposed because they are unable to leave (hence are captive) and do not want to offend their caregivers for fear of reprisals.

Genuinely informed consent can be particularly difficult if the client has sought out a healer in a group of which he is a member. As will be discussed later in this chapter, when client and healer share beliefs, the client may question less, trust more, and find it difficult to refuse or to discontinue treatment. If healing takes place in a religious healing circle, such as a charismatic group, the client may be made to feel sinful if he or she resists the ministrations of the group. Such settings are implicitly coercive and informed consent greatly attenuated.

The doctrine of informed consent only became fully developed in the twentieth century, and its utility has been hotly debated in conventional medicine. This chapter will examine the legal doctrine of informed consent; its history; models of informed consent; the philosophical basis of informed consent; informed consent, communication and complementary and alternative medicine; important elements of informed consent such as truthful disclosure, protection of autonomy (which includes freedom from coercion and the right to refuse treatment) and the promotion of beneficence. Claims of efficacy and the verification and disclosure of risk (aspects of the ethical requirement of non-maleficence), which are an important part of the information given to the patient, will be discussed in chapter eight.

The Legal Doctrine of Informed Consent

The requirements for informed consent are that it be voluntary; given by a mentally competent person; refer to the treatment and the person giving it; be given only after the patient has received enough information to make an intelligent decision (Picard, 1984, 53). Consent is necessary but not sufficient. The onus is on the practitioner to ensure that a procedure or product is safe and effective.

If a patient or client has not consented to an intervention or treatment, the physician or practitioner can be sued for battery or negligence. Autonomy is severely compromised if consent is not truly informed and the patient agrees to an intervention without understanding what it entails or gives it under coercion. Consent can be express, either written or verbal, or implied, in the example of a patient who holds out her arm to have a blood sample taken. In emergencies, consent can be waived (Picard, 1984, 43-45). When a patient is incompetent to consent, a person authorized to do so may act on his or her behalf.

In spite of the requirement for sufficient information, informed consent is one of those concepts that some physicians reduce to a quick exchange of information and a request to sign a form. While some doctors think that asking a patient to read and sign a form satisfies their obligation to obtain informed consent, its proper application requires effective communication. According to Picard, who wrote this passage four years after two important Canadian Supreme Court of Canada decisions:

The uniqueness of the concept of consent in medical negligence law is its concern, not with the usual negligence criteria of reasonable skill, knowledge, and judgment, but with communication, rapport and sensitivity. A common feature of the cases examined [in her book] is no communication or poor communication between doctor and patient. Thus it would seem that the Supreme Court of Canada decisions were aimed at improving doctor-patient relationships (Picard, 1984, 113).

The doctrine of informed consent rests on the legal and ethical obligation to respect the autonomy of the mentally competent adult.⁷⁶ For the consent to be valid, according to an article in the Canadian Medical Association Journal (Etchells, et al., 1996a, 387-391), the physician must disclose information so as to promote the patient's informed participation and trust between patient and physician. Information about treatment must describe it and its expected effects (this includes such elements as length of time off work, when sexual activity may be resumed, if relevant, scars that may remain). Other requirements of a valid informed consent are that the doctor must explain the consequences if treatment is delayed or refused. Alternative options, which may include no treatment, should be described along with their benefits and risks. This is usually understood to mean alternatives in the conventional field but physicians could expand this to include the techniques or treatments of alternative medicine.

If consent is to be truly informed the patient must *understand* the information given about his/her condition, diagnosis, prognosis and proposed treatment as well as its risks and benefits. After sufficient time has been given to allow the patient to ask questions, perhaps take information home and discuss it with family members, the patient is ready to make a decision. Anything less than this may mean that the patient will have insufficient information or sufficient information but no time to digest it. While the hospital may have a

⁷⁶The age of majority varies from province to province. However, it is generally agreed that an underage person can consent to treatment if he or she can understand the "nature and consequences of the particular treatment." Picard says that this is a right long recognized in English law, but that many physicians usually feel more comfortable if parents consent (Blackstone, *Commentaries on the Laws of England* 454 (1765), quoted in Dickens, *supra* n 95 at 94; *Gladwell v Steggall* (1839), 5 Bing N.C. 733; *Ash v Ash* (1696), 90 E.R. 526 in Picard, 1984, 55). See also Somerville, *Consent to Medical Care* (1979). In Québec, a person between the ages of 14 and 18 is a mature minor and may consent to treatment without parental knowledge. However, if the person is held in hospital for more than 12 hours, parents must be informed.

blanket consent form, many procedures cannot be performed until the patient signs a consent form for a specific procedure which outlines its benefits and risks. This is an almost universal requirement for surgery. In some cases, the patient has all the information but is unable to give consent due to mental impairment or mental incompetence. The doctor is then obliged to follow a legally prescribed procedure to obtain consent. He/she cannot sign the consent form himself.⁷⁷

As noted before, with the growing interest in alternative medicine, a question that should be asked is whether doctors are obliged to be familiar with alternative medicine and include it when recommending alternatives.⁷⁸ A requirement of due diligence may oblige a physician to at least let a patient know of the availability of an alternative therapy. Michael H. Cohen argues that the growing body of research that determines which complementary and alternative practices are safe and effective could lead to physicians being found liable for not recommending an alternative. Those who dismiss alternative medicine, he believes, could be sued for practicing substandard medicine (Cohen, 1998, 59). Cohen cites the case of *Moore*

⁷⁷Although different provinces have different regulations governing a declaration of mental incompetence, in general, all people are presumed to be legally competent unless they have officially been placed under curatorship/guardianship for reasons such as dementia.

Mental capacity differs from legal competence. It means that a person can understand information sufficiently well to make a decision and understand its consequences. Capacity is specific to a particular situation. For example, some people are incompetent to handle financial affairs but able to decide whether or not they want treatment. In common law Canadian provinces, even a minor can give consent if he or she has the capacity to understand information about treatment and weigh its risks and consequences (Etchells, et al., 1996b, 657-661). A person can be incapacitated because he is unconscious, suffers pain and injury to the point of incoherence, is affected by alcohol or illegal or legal narcotics (see Rozovsky, 1997, 8).

⁷⁸On September 22, 1997, the College of Physicians and Surgeons of Ontario adopted a new policy which states that no doctor can be sanctioned for referring a patient to an alternative medical practitioner (College of Physicians and Surgeons, 1997). In some provinces, physicians are disciplined if it is known that they either practice alternative medicine or refer patients to alternative medical practitioners.

v Baker in which a patient sued because her neurologist did not tell her that chelation therapy,⁷⁹ which is considered to be a type of alternative medicine, could have prevented a post-surgical blood clot. The surgeon unblocked her carotid artery with a carotid endarterectomy but by this time the patient had suffered permanent brain damage. The court concluded that the plaintiff was not required to have given the patient information about chelation therapy because this therapy was not generally accepted by “reasonably prudent physicians.” This was accepted on appeal (Moore, 1991 U.S. Dist. LEXIS 14712, at *2 in Cohen, 1998, 61-62; 152).

One could also ask if alternative practitioners should be able and ready to recommend alternatives within the alternative medical field. Medicine, traditionally, has viewed the doctor as “a benevolent parent making decisions for dependent, ignorant children” (Cohen, n.d., 2 of 7.<http://cpmcnet.columbia.edu/dept/r...legal/cohen.fixedstar.text4.html#4>). Michael Cohen believes that depriving patients of the right to choose alternative medical treatment is paternalistic and violates autonomy. He claims that orthodox medicine puts the burden of proof on alternative practitioners to prove that they will not harm (Cohen, 2 and 3 of 7). When law and medicine speak of disclosure of alternative treatments, they refer to conventional and available alternatives. In most American jurisdictions, no requirement exists to disclose to patients that headaches can be treated through therapeutic touch or hypnosis (Cohen,internet site as above but text2.html#2, 1 of 9).

Lawyers Julie Stone and Joan Matthews also point to the traditionally restricted understanding about what sort of alternatives should be recommended to patients. Like

⁷⁹Chelation therapy was developed after World War II to cure heavy metal toxicity. It is highly invasive as it involves the intravenous or intramuscular administration of Ethylenediamine tetra-acetate (EDTA).

Cohen, they believe that as knowledge of the safety and efficacy of alternative medicine is acquired, one could create a “legal duty on the part of an orthodox practitioner to recommend an alternative therapy, if this is the most appropriate form of treatment for the patient” (Stone and Matthews, 1996, 179-180).

Cohen believes that if the duty to refer is expanded to include conventional and alternative medical practitioners, then the law itself will integrate the two types of medicine. If this duty is imposed on conventional and alternative practitioners “the two paradigms are no longer separate but function integratively in search of knowledge” (Cohen, 1998, 111). This is an approach focused on patients’ needs rather than on professional competition and will, according to Cohen, expand the doctrine of informed consent (Cohen, 111). The increased number of medical schools teaching medical students about complementary and alternative medicine might also address this issue.

The Legal History of Informed Consent

Although patients have been required since ancient times to consent to surgery, the right was “narrow in scope” and confined to the “right of refusal” (Katz, 1984, 49). Two frequently cited cases from the early twentieth century, *Pratt v. Davis* (1905) and *Schloendorff v. The Society of New York Hospital* (1914), simply “re- affirmed a citizen-patient’s ...right to be free from (offensive) uninvited contact” (Katz, 50). *Pratt and Schloendorff* led physicians to become more cautious about proceeding with treatment over the objections of patients but hospitals continued to focus more on concern for their patients than for their patients’ freedom of choice (Katz, 58-59).

The doctrine of informed consent flies in the face of more than 2,000 years of medical practice. It represents a radical departure from a medical tradition that historically viewed

the patient as someone requiring “caring custody” (Katz, 1984, 3, 2). In its present application, the doctrine is relatively new. Jay Katz speaks of its birth-date as October 22, 1957 with the case of *Salgo v. Leland Stanford Jr. University Board of Trustees* (Katz, 60). However, as Cohen points out, the principle was first stated in the Nuremberg Code which was produced after the post-World War II Nuremberg trials of Nazi physicians (Cohen, 1998, 60).

By the late 1950's, American judges began to ask whether patients should not only “*know what* the doctor proposes to do but also *to decide whether* an intervention is acceptable in light of its risks and benefits and the available alternatives, including no treatment” (Katz, 1984, 59). When Martin Salgo (*Salgo v. Leland Stanford Jr. University Board of Trustees*, 1957), a 55-year-old partially paralyzed by an aortography, which was experimental⁸⁰ in his part of the United States, claimed that he had not been apprised of the risks and sued, the judge’s pronouncements on informed consent were clear: “A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.” Justice Bray then had second thoughts about the dangers of disclosure but found answers in what Katz calls a “charmed new phrase, [--] ‘informed consent’”. The judge went in two contradictory directions. He suggested discretion in discussing risks but also said that discretion must be used in such a way that it is “consistent with the disclosure of facts necessary to an informed consent”(Katz, 1984, 60-61).

The *Salgo* case, like that of the later *Natanson* case which involved cobalt radiation

⁸⁰When a procedure is experimental, more extensive information is usually required. The patient should know that he/she is part of a study and be told what the standard treatment is.

(*Natanson v. Kline*, 1960), involved new medical procedures which had the potential to injure. Katz surmises that the justices in both these cases must have insisted on conversation about risks because of the new and formidable risks posed by technology. Cases as far back as 1767 led courts to warn physicians that they were taking a personal risk whenever they used experimental procedures (Katz, 1984, 63).

Alternative medicine has become newly popular because many believe that it poses very few risks. If the legal development of the doctrine of informed consent hinged on the rise of risky technological medicine, some might think that the need for informed consent (and any further development of the doctrine) would be unimportant in complementary and alternative medicine. However, as the next chapter on safety and efficacy will attempt to demonstrate, alternative medicine can present not only material but psychological and even spiritual risks. Informed consent is crucial to the ethical practice of any form of treatment that promises to heal. This is recognized by the Casey House Hospice for people living with HIV. A person responding to a request for information for the Health Canada/York University report *Complementary and Alternative Health Practices and Therapies - A Canadian Overview*, said that when patients are unable to consent because of dementia or because of coma, the family is asked to consent to alternative therapies on the patient's behalf if the staff believe that these therapies will help. If no family exists, alternative care is not given no matter how beneficial (York University Centre for Health Studies, 1999, 85).

History of Standards of Disclosure

The standards of disclosure are the responsible patient standard; the particular patient standard; the responsible physician standard and the particular physician standard. The responsible patient and responsible physician standard refer to what the average patient or physician would want to know or would ordinarily disclose. The particular patient or

physician standard refers to information specific to that patient or physician. For example, in the *Reibl v. Hughes* case (explained in footnote 81), information about delays was particularly important to Mr Reibl because he was close to receiving a pension. In the case of *Hopp v. Lepp*, to be discussed later in this chapter, the patient demanded the particular physician standard (and lost) when he insisted on knowing whether or not the surgeon had performed the procedure before.

Before another landmark case, *Canterbury v. Spence*⁸¹ (U.S.A., 1972), the legal standard for informed consent was known as the “reasonable doctor” standard. What *Canterbury v. Spence* did was to shift the emphasis to “the reasonable patient” standard. The *Canterbury v. Spence* case defined the standards of disclosure as that which “a [reasonable] *prudent* person in the patient’s position” would want to know. It rejected the more subjective test (the particular patient standard) of “what an *individual* patient would have considered a significant risk” (Katz, 1984, 74-75). The decision represented “a change from the extent of the necessary disclosure being determined by the medical profession ...to assessment by lay standards” (Somerville, 1979, 17). It went beyond previous judgements in elaborating the standard for disclosure, stating that all risks, alternatives and the results if no treatment were chosen must be disclosed (Katz, 75).

What a patient might want to know and what a doctor thinks ought to be disclosed are often

⁸¹Mr. Canterbury was a 19-year-old who underwent a laminectomy for severe back pain in 1959. Shortly after the surgery he needed to urinate, got out of bed by himself and fell. Within a few hours he was paralyzed from the waist down. When Judge Robinson rendered his opinion in 1972, it was based on the fact that Dr. Spence had been negligent in performing the laminectomy and, appended later to the claim, had been negligent in failing to warn of the risks of paralysis. The judge was disturbed that a patient was offered a cure for a relatively minor disability without being told of the risks of a major disability. The judgement rejected the charge of battery but “grounded the disclosure requirement in negligence law,” as had the 1960 Natanson case. The duty to warn is a part of due care and due care is part of negligence law (Katz, 1984, 71-73)

in conflict. Dr. Spence, the defendant in *Canterbury*, claimed that communicating the risk of paralysis to a patient “is not good medical practice.” He suggested that disclosure “might deter patients from undergoing needed surgery and might produce adverse psychological reactions” which could compromise the success of surgery (Katz, 1984, 74). Dr. Spence was arguing for therapeutic privilege in which what to disclose is entirely in the hands of the individual physician. In opting for the reasonable patient rather than the individual, or particular, patient standard, the court created problems which are at the root of the difficulties in applying the informed consent doctrine fairly. In choosing this “objective standard”, says Katz “self-determination was given... short shrift” (Katz, 1984, 75- 76).

The Canadian standard for what constitutes sufficient information to help a patient give informed consent was set by *Hopp v. Lepp* (1980) and *Reibl v. Hughes* (1980)⁸². Before the Supreme Court decisions on these cases, a physician only needed to disclose risks “that his colleagues would normally disclose about the proposed treatment” (Picard, 1984, 68). In addition, the doctor had to take into account the particular patient’s intellectual and emotional characteristics, as well as the relationship between himself and the patient. This standard of disclosure is called “the professional disclosure” standard. Until the two

⁸²In *Reibl v. Hughes*, John Reibl won a settlement of \$225,000 because several elements of information were missing when he gave his consent to surgery. The 44-year-old Mr. Reibl suffered from severe headaches caused by arterial occlusion which reduced the blood flow to his brain. Whether or not he chose to have the surgery, he was at high risk for stroke or death. He then suffered a crippling stroke during or immediately following surgery. The stroke was a possible risk of the type of surgery performed on him but he had not been told. Nor was he told that the surgery could be postponed to a later date. He had wanted to continue in his job for one-and-a-half years so as to obtain a full pension. He lost the pension because of the stroke. Justice Laskin stated that a reasonable person in his position would, balancing the probabilities, have opted against the surgery. He held that in determining the consequences of the disclosure of each risk, the physician should employ an objective standard and ask what a prudent person in the patient’s position would do if properly informed (Picard, 1984, 71-72).

landmark 1980 cases, the patient in Canada was measured subjectively rather than by an objective “reasonable patient” test (Picard, 68). The subjective assessment, made by the doctor, was to consider what he or she thought the patient might want to know (Picard, 79). Nonetheless, patients in Canada were expected to recognize that all medical procedures carry risks and such *sequelae* as infection were not disclosed as they might frighten the patient. Physicians were to disclose probable effects and unusual risks (Picard, 1984, 69).

In *Hopp v. Lepp*, 66-year-old Mr. Lepp sued on the grounds of battery, stating that his consent to a hemilaminectomy for a slipped disc was not informed because he did not know that Dr. Hopp had not performed a hemilaminectomy before. Dr. Hopp had assisted more senior surgeons performing this procedure when he was a resident but this was his first as a newly-qualified orthopaedic surgeon.

Mr. Lepp also objected to being told that the operation was as easily performed in Lethbridge as in Calgary.

The patient’s objection was to what he believed to be the limited scope of disclosure. Mr. Lepp did not recover from the hemilaminectomy, performed in Lethbridge, Alberta. Because he did not do well, he was referred to a neurosurgeon in Calgary who found extruded disc material. The trial judge determined that one could not tell whether this condition existed before or during the surgery or whether it followed it. No damages were found by the trial judge and the supposed risk of disc material could not be proven to be the result of anything done or not done by the surgeon. Nor could it be seen to be a risk of surgery. The judge held the consent to be valid because the doctor’s experience is not a part of the information disclosed to a patient and because it was correctly stated that surgery could be performed as well in Lethbridge as in Calgary (Picard, 1984, 73-74).

According to Picard, in *Hopp v. Lepp*, the Chief Justice of Canada “began the restructuring of the law on informed consent. The basic right to control one’s body and be informed was accepted and the parameters for the scope of the disclosure were roughly outlined.” The task was completed, dramatically in Picard’s view, with the case of *Reibl v. Hughes* which led to battery action cases being restricted to those in which surgery or treatment are given with no consent or beyond the limits of the consent given. Up until the *Reibl* decision, voluntary disclosure, as noted before, was made according to a standard of “professional disclosure” (Picard, 77-78). Chief Justice Laskin rejected this in *Reibl v. Hughes*, saying:

To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty... (Laskin in Picard, 78).

He thus replaced the “professional disclosure” standard with one similar to the U.S. “full disclosure” standard. Chief Justice Laskin said:

What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge (Laskin in Picard, 79).

Many people think that Chief Justice Laskin’s conclusions mean that all known risks and benefits must be described. In fact, the *Reibl v. Hughes* judgement, like *Canterbury v. Spence*, set the standard of the reasonable person (Rozovsky, 1997, 9) which is:

...what the average prudent person, the reasonable person in the patient’s particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him (*Reibl v. Hughes*, supra, note 1, 14 C.C.L.T., at 21 cited in Rozovsky, 1997, 9).

The information about risks need only include material risks which would “influence a person’s consent to treatment” (Rozovsky, 1997, 9).

The way in which some physicians misinterpret the reasonable patient standard can undermine the principle by bombarding patients with information they do not require, so as to cover all eventualities. The reasonable patient standard can lead to the travesty of relying on long-winded consent forms as an assurance that informed consent has been obtained. Some interpret the requirements of informed consent in a way that enshrines the Kantian concept of man as a totally reasonable being. The physician may point to a detailed consent form and claim that all risks have been disclosed to the patient. An extreme interpretation of the reasonable patient standard does absolutely nothing for the individual expectations and needs of the individual suffering person.

Doctors can go beyond the reasonable patient standard and impart information that their particular patients seem to require. What is a risk to one person may not be to another (Rozovsky, 1997, 9). People's risk budgets differ. One person might accept surgery with a thirty percent failure rate; another might accept only a five percent failure rate. What Chief Justice Laskin said was that "common, everyday risks need not be disclosed" (Laskin in Picard, 1984, 97). As Picard says, this may be practical but one may not easily get doctors and patients to agree on what is a common risk (Picard, 97). In fact, one commonly applied standard is to disclose all common risks, even if they are minor, and all major risks, even if they are rare.⁸³ For example, the anti-cancer drug Tamoxifen, which carries a risk of endometrial cancer, has been heavily promoted as a preventative treatment for healthy, cancer-free women with a first-degree relative afflicted with breast cancer. Those with many first degree relatives with breast cancer might think the risk minor; those with only one

⁸³The research standard for consent is different and more rigorous. Research subjects must be told that the drug or technique is experimental and all interventions required by the research study must be explained (*Halushka v. The University of Saskatchewan* (1965), 53, *Dominion Law Reports* (2d) 436).

might find the threat of endometrial cancer to offer more risk than benefit.

Whatever standard is followed, either the “reasonable” or the “particular” patient model, both represent a departure from the earlier standard of the “reasonable” or “particular” doctor (Somerville, 1979, 17).

Models of Informed Consent

Howard Brody, in *The Healer's Power*, looks at three models of informed consent: the paternalistic model which emphasizes the beneficence of physicians and rejects the idea that patients can meaningfully participate in their care, the legalistic model which focuses on total disclosure of all risks patients might need to know, and Jay Katz' conversation model which emphasizes the physician's role as facilitator in conversation with the patient. Brody sees this last model as the most fruitful. It cuts across the legalistic aspects of the doctrine of informed consent, emphasizing not only conversation between patient and physician but recognizing the imbalance of power which makes such communication difficult (Brody, 1992, 90-92). As Brody points out, ethicists tend to see disclosure and participation in decision-making as closely connected. However, according to Brody, many patients say they want information not so much because they want to make informed decisions but because being given information makes them feel respected as people and not ignored as disease entities (Brody, 89 and see Lidz et al., 1983 in Brody, 89). As Fay Rozovsky, who co-wrote the first edition of Lorne Rozovsky's book on informed consent, once pointed out in a public lecture, consent is a process, not a form (lecture, 1980). Consent is, in fact, a conversation between two individuals in which the individual with the greater knowledge and power honours, at the very least, the Canadian standard of disclosure, that of the “reasonable person”.

The doctrine of informed consent initially met with considerable resistance. Many authors have questioned whether informed consent can have any reality. Halperin speaks of misinformed consent when the “reasonable” rather than the “particular” patient standard is applied (Halperin, n.d., 175-176). In 1985, the British House of Lords denied a patient’s claim based on what they regarded as the “American” doctrine of informed consent (*Sidaway vs. The Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* in Schwartz and Grubb, August 1985, 19-25).⁸⁴ As the case described in the footnote makes clear, the principle of autonomy and the way it is applied to the doctrine of informed consent is grounded in cultural and philosophical beliefs that vary from country to country. However, one might ask whether the judges in this case were, perhaps, over-emphasizing a more paternalistic doctor-patient relationship that is now as outmoded in England as it is in Canada.

⁸⁴ In 1960 Mrs Amy Sidaway had her spine operated upon by a respected surgeon who examined her annually for the following ten years. When the pain returned the surgeon recommended she be readmitted to a National Health Service hospital for more tests. In a scenario familiar to modern Canadian patients, her admission was delayed by a waiting list of several months and a hospital strike. She got the tests in 1974 and the surgeon performed a laminectomy. The surgeon told her of the possibility of nerve root disturbance but not the one to two percent chance that her spinal cord could be very seriously damaged. It was damaged and the patient became paralyzed and wheelchair bound. She sued on the grounds that she was not informed of the risks of surgery.

The judge was faced with a choice between legal theories: the “American” rule which is based on a patient’s right to information necessary for informed choice, and the English tradition of basing a judgment on claims of negligence. The judge rejected the “American” doctrine of informed consent and found that the doctor was not negligent by a reasonable physician standard. He noted that not all responsible physicians told their patients of the material risks of laminectomy.

The patient went to the Court of Appeal and lost. One of the three judges said: “[i]t is doubtful whether [informed consent] would be any significant benefit to patients, most of whom prefer to put themselves unreservedly in the hands of their doctors. This is not in my view “paternalism,” to use an evocative word used in argument. It is simply an acceptance of the doctor/patient relationship as it has developed in this country.”

Mrs Sidaway then was permitted to appeal her case to the House of Lords who dismissed the case and what they felt was an alien American doctrine of informed consent (Schwartz and Grubb, August 1985, 19-22).

The Philosophical Basis of Informed Consent

The belief that people have a right to individual self-determination is a doctrine of the Enlightenment. In the eighteenth century, the idea that people had the right “not to be interfered with in their pursuit of life, liberty and happiness” was perceived to be a natural right (MacIntyre, 1984, 69). The concept of the patient’s right to self-determination became reified into concrete action with the rise of the patients’ rights movement in the 1960’s. However, difficulties arise in the translation of a philosophical concept to the clinical setting. The exigencies of medical practice often demand speed, which militates against philosophical reflection. Doctors and nurses are, on the whole, pragmatists. It is for this reason that informed consent is often reduced to the formality of a form. This may assure doctors that they are protected from lawsuits more than it actually informs the patient.

The right of self-determination assumes that humans are able to absorb and weigh information, make decisions and plan courses of action (Katz, 1984, 104). However, the “abstract notions of rights” has not been integrated “with a psychological view of human beings’ capacities for autonomous choice.” If we claim that individuals possess certain rights, we must assume that they can make use of them (Katz, 105). Katz asks if the “observed incapacities of patients to make decisions are fundamental to... patienthood, or engendered... [by] physicians’ conduct” (Katz, 105). One might add that the hospital environment itself tends to impair the sense of self-agency. Patients are rushed through procedures on a timetable of the hospital’s making. Refusals or delays at any point are deeply annoying to staff. In alternative medicine, the state of “clienthood” may in some cases impair the free exercise of self-determination. The initial choice of alternative medicine may be a way in which people exercise their right of self-determination. Once involved in an alternative form of healing, however, the healer or healing group may be so

persuasive that one's psychological capacity to freely choose may be jeopardized.

Katz states that the right to self-determination is often used interchangeably with autonomy. In Katz' schema, what he calls "psychological autonomy" describes the individual's capacity "to reflect...[upon] contemplated choices and to make choices." In his view, psychological autonomy "'informs' the right to self-determination by explaining, refining, and pointing up human capacities and incapacities for the exercise of such a right" (Katz, 1984, 105-106). Katz focuses on the "psychological capacities that underlie rights" because "assumptions about human psychology have shaped decisively the views on all political, legal, and moral rights to which persons are supposedly entitled" (Katz, 106).

The concept of pure autonomy or pure freedom can be dangerous. Immanuel Kant isolated man's rational nature; John Stuart Mill believed in it but was aware of people's tendency to irrationality and the need for human beings to help each other choose the good over the bad (Katz, 1984, 123, 124). Distortions of the Kantian philosophy occur when individuals do not grasp the fact that autonomy does not stand alone. Individuals do not have the right to whatever they want. Mill is rarely invoked but might profitably influence the debate. Mill believed that individuals often needed exhortations to help judgement and strengthen will (Katz, 123).

Informed Consent, Communication, and Complementary and Alternative Medicine

The doctrine of informed consent requires not only sufficient information but effective communication. Beneath poor communication may lurk the feeling on the part of doctors that sick people's task is to trust the doctor and stop asking questions. The chairman of a patients' rights association quotes a story told by the satirist George Mikes. A visiting

specialist was touring the wards of an English hospital, surrounded by admiring followers. "As he was about to pass a bed, an elderly patient raised himself on his elbow and said, 'Excuse me, doctor, I know it's none of my business, but how am I?'" (Coy, 1981, 55).

The doctrine of informed consent, when applied to complementary and alternative medicine, may have to be expanded to include the requirement to disclose more information than would be usual in the conventional medical setting. Of great importance is disclosure of all known risks, information about the right to refuse treatment, information about the practitioner's ability to heal (efficacy), information about the practitioner's training and professional accountability. All medical doctors, licenced in Canada, are required to submit to a specific set of standards and are accountable to a professional group. Members of the public may write to this group if they are dissatisfied. In the alternative setting, this may not be evident. The alternative practitioner should also know how to refer the patient elsewhere if necessary or if either party desires it.

How freely does one choose when considering treatment from an alternative healer? Informed consent becomes an issue between patient and doctor in conventional medicine because of loss of trust, whereas some individuals may suspend skepticism when meeting with an alternative practitioner (See Buckman, 1993, 78, 83, 113). The relationship between patient and physician in a hospital is often a relationship between two strangers who must get to know and trust each other very quickly. If the relationship fails, the patient can appeal to his right to informed consent. When trust is high, as it may be between client and alternative healer, normally reflective and intelligent people may well lower their level of suspicion and accept treatment that they might otherwise question. Do those who consult alternative practitioners receive sufficient information not only about their illness and its treatment but about the ability of the practitioner to effect change? Or do they merely feel

reassured and therefore hope for change without inquiring too closely into how this will come about? Some who consult alternative practitioners may be predisposed to trust because of negative experiences with the practitioners of biomedicine. The danger inherent in this confidence, which could take on the quality of an almost religious belief in the healing power of the practitioner and the efficacy of the treatment chosen, is that individuals may unwittingly place themselves in the hands of those with little scientific training, who do not truly understand the limits of their competence and who are unaccountable to any professional organization.

Important Elements of Informed Consent in Complementary and Alternative Medicine

This section will discuss more fully the application of important elements of the legal requirements of the doctrine of informed consent to the practice of complementary and alternative medicine: truthful disclosure, protection of autonomy and the promotion of beneficence, balancing autonomy and beneficence, threats to autonomy such as coercion and shared beliefs. Other elements of informed consent include balancing and disclosing the benefits and risks of a treatment and, of great importance in complementary and alternative medicine, ensuring a system of accountability and an acceptable level of training. Following is a discussion of all but the last three of these elements. Risks and benefits will be discussed in Chapter eight; the role of the state in accountability in chapter nine and training in chapter ten.

Truthful Disclosure

Truthful disclosure requires not only honest disclosure but sufficient knowledge about a patient's/client's problem and the experience, skill and dedication to propose and carry out appropriate treatment. It also demands the ability to reveal all necessary information in

language that the patient/client can understand and the capacity to respond non-defensively and comprehensively to questions. Alternative practitioners are said to be better at communicating with clients than doctors of biomedicine. Until very recently, Canadian medical schools have placed high value on top marks in science and almost none on interpersonal skills. Therefore, one would think, the obligation to ensure that the patient gives informed consent would be more fully realized in alternative than in conventional medical practice because of alternative practitioners' supposedly superior communication skills.

This is probably not the case. The ability to communicate is a very important part of ensuring that consent is informed. But what is communicated is crucial. Much has been written about the issue of incompatible discourse between alternative and conventional medicine. Different alternative medical theories propound very different views of the causes and nature of illness and the nature of the human body. For example, conventional science and medicine does not recognize the meridians of acupuncture, nor does it adhere to the belief that the body is charged with invisible energies that need to be balanced if healing is to take place.

If the doctrine of informed consent as understood in Canadian law is applied to alternative practitioners, it may be difficult to defend, from the conventional perspective, a diagnosis and prognosis based on alternative understandings. To say: "your cancer is caused by toxic energies communicated to you from the universe (or from electromagnetic fields) but I can easily cure it with Essiac" (an unproven remedy developed by Renée Caisse in the 1930's who branded her product by reversing the letters of her name) would, from the perspective of conventional medicine, be deemed a fraudulent communication. Legally

however, a practitioner has to intend to deceive.⁸⁵ Wise alternative practitioners do not make sweeping claims. However, even if the practitioner's understanding of illness and diagnosis is radically different from that of conventional medicine, he or she should be able to discuss benefits and risks according to the standards of his own discipline and from within its paradigm.

Cohen points to the fact that some practitioners who practice a therapy that cannot effect a cure may honestly, but mistakenly, inform the patient that they can cure. While such practitioners may be found criminally liable for practicing medicine unlawfully, they have not committed fraud because fraudulent intention is missing. The best course of action, according to Cohen, is to say to the patient:

I am not diagnosing or treating your medical condition. I am diagnosing and treating the vital energy in your field. The risks are as follows, and there is limited scientific evidence of efficacy. The treatment could, in my view, conceivably translate into physiological benefits, but you should consult your medical doctor regarding your disease or condition (Cohen, 1998, 107).

Such a clear statement satisfies the first part of informed consent, which is information. The practitioner of alternative medicine must be able to give the client information about her goals and how he or she intends to proceed. This will ensure that the client will, for example, know about direct adverse effects which are side effects that are the immediate result of the intervention. In the case described at the beginning of this chapter, the practitioner only mentioned contraindications to the procedure he offered after he was asked. The practitioner must also make his definitions and descriptions clear to the client so

⁸⁵Lawyer Michael H. Cohen speaks of the overly broad concept of what constitutes fraud. Some believe that alternative medicine is itself fraudulent. He cites the legal definition of fraud as "anything calculated to deceive, including all acts, omissions, and concealments involving a breach of legal or equitable duty, trust, or confidence justly reposed, resulting in damage to another or by which an undue and unconscionable advantage is taken of another" (Speiser et al., 1992, vol 9, 322.1, at 212 (citing cases) in Cohen, 1998, 107).

that no misunderstandings exist between client and practitioner. The practitioner in the case described was vague. He may have communicated poorly because he lacked knowledge and wished to hide this deficiency. Or, more seriously, he may have deliberately tried to mystify his client, relying on the client's trust. It seems that he realized that his own authority was insufficient to inspire trust which led him to augment his authority with that of his teacher.

The other side of informed consent is the autonomous client's choice. The difficulty, in both the conventional and alternative medical setting, rests on the fact that while most people are legally competent, their judgement can be impaired by need, emotion, illness and fatigue. We are not the Kantian creatures of pure reason. The doctrine of informed consent often founders on this very point. Jay Katz points out that even the most medically knowledgeable and highly educated will often leave decisions up to their physicians when they are very ill (Katz, 1984, ix). These types of dependency needs are easily exploited, especially when the practitioner is part of a healing cult. In the case described at the beginning of the chapter, the client appeared to have no dependency needs and so she was not swayed by the practitioner's persuasive rhetoric. This is not always the case. However, it is important not to over-emphasize a client's vulnerability. When faced with choices, all people are constrained by outside pressures such as family expectations, the need to get well quickly so as to remain employed and other naturally coercive factors (see Stone and Matthews, 1996, 261). Laws exist to ensure that excessive coercion is avoided and to recognize that some people are genuinely incapable of autonomous action. It is paternalistic to assume impaired judgement when a patient refuses conventional medical treatment. Although Stone and Matthews underline this as a problem when people reject orthodox treatment (Stone and Matthews, 261), alternative practitioners can be equally coercive. Individuals who do not respond well to various types of psychological therapy may be

deemed resistant. Those who ask too many questions about the ingredients of a herbal remedy may be told, peremptorily, that they lack trust. A reluctant participant in religious healing may be told she lacks faith.

Protection of Autonomy and the Promotion of Beneficence

Autonomy vs. Beneficence

Autonomy means self-government (*autos* - self; *nomos*- rule of governance) and was first used to describe Greek city states. The autonomy model has come to be used as a model for decision-making because members of modern society do not share many values in common (see Darvall, 1993, 17).

Stone and Matthews speak of complementary medicine's role as a supposedly more "patient-centred" form of healing than conventional medicine. They ask how complementary medicine differs from conventional medicine, considering that conventional medicine also has as its goal the healing of the sick. "Is being patient-centred the same as respecting the patient's autonomy...?" they ask (Stone and Matthews, 1996, 257). Given that autonomy is so highly valued a precept in ethics and in law, they ask if "the principle of respect for autonomy is at its highest in relation to patient-centred therapy" because, if a healing practice is centred on the patient, then one might presume that it respects the wishes and values of patient. They argue that it is important to look at this issue critically because of the common assumption that alternative and complementary medicine automatically respects autonomy because it respects patients (Stone and Matthews, 257-258).

The concept of beneficence in medicine is as old as Hippocrates. All who heal the sick tend to focus first on the need to alleviate suffering, or at least not harm. Valuing autonomy, historically, has been viewed as considerably less important. Tensions arise when what the

doctor or practitioner wants to do, and genuinely believes is for the good of the patient, is at variance with what the patient wants. Stone and Matthews, discussing this issue, ask whether health care professionals are more vulnerable than other professionals. Lawyers, they say, tend not to appreciate clients who ignore their advice. However, lawyers are unlikely to try to have non-compliant clients declared incompetent. Paternalism, as Stone and Matthews say, is often justified by the argument that refusal of a particular medical intervention could lead to death (Stone and Matthews, 1996, 264). As Jay Katz says, surveys show that doctors are more afraid of death than the average person (Katz, 1984, 219). Consequently, some physicians may withhold information from patients whose health is in danger so as to persuade them in a particular direction (see Stone and Matthews, 265). It should also be remembered that many physicians in teaching hospitals are very young and so may find death more alarming than their elderly patients or their older colleagues. Complementary practitioners may be more accepting of death but, like any medical practitioner, do not usually welcome it as an outcome if improvement in health initially seemed likely.

In 1984, Daniel Callahan, now an ex-officio director of the Hastings Center in New York, pointed out that our overvaluing of autonomy tends to diminish the sense of moral obligation one has towards a community (Callahan, 1984 in Darvall, 1993, 16). While the focus on autonomy was a natural reaction to the medical paternalism of the past, the patient, living in a community of “moral strangers” (ethicist James Childress’ term), came to rely on the contractual obligations between him/herself and caregivers (MacIntyre, 1977, 197, 210; Childress, 1982, 49; Childress, 1997, 29, 43; and see Engelhardt, 1986, 251, 47-48 in Darvall, 1993, 15-16). In this system “...there is no room for extra-contractual commitments such as altruism, beneficence or self-sacrifice” (Callahan, 1981, 19, 20 in Darvall, 16). James Childress believes that strangers can still trust if commonly-agreed-to rules and guidelines safeguard practitioners and patients who can then “come together as

friendly strangers” (Childress, 1997, 48).

In the field of alternative medicine, one needs to ask whether people ought to be protected from making ostensibly irrational decisions. The difficulty lies in the fact that, in our society, many people, especially medical people, believe that much of alternative medicine is inherently irrational. How does one protect autonomy but offer guidance? Should the consumers of alternative medicine be left to their own devices (the independent choice model) with only the warning “*caveat emptor*”? This was the conclusion of the Québec *Office des professions* which analyzed a study of alternative medicine conducted in the early 1990's and, in 1993, recommended to a parliamentary commission on alternative therapies that no government legislation was required beyond a few amendments to the Consumer Protection Act. The *Office des professions* concluded that the controls of the marketplace were sufficient to protect consumers of alternative medicine. This model sees alternative medicine as nothing more than a purchased commodity.

Do practitioners of alternative medicine perceive themselves as commercial purveyors of a service or product or as healing professionals? How the practitioner defines him or herself is relevant to a discussion of informed consent because it determines what the professional believes should be his or her relationship with the client. Hauerwas says that in the ideal setting, the conventional physician pledges steadfast presence and care and the willingness to communicate his own uncertainty and fallibility. While this can be disquieting to those who seek a savior in their illness, it is an important part of the ideal of covenant entered into by physician and patient (Hauerwas, 1986, 51-52). Medicine of this sort, however, can only, in Hauerwas' view, exist with the support of a caring community. Ramsay describes the principle of informed consent as the “cardinal *canon of loyalty*” which joins people in medical practice and investigation. Patient and physician are “joint adventurers in a

common cause” (Ramsay, 1970, 5-6). His model is one of partnership. The conventional physician, however, often sees him or herself in a contractual relationship with the patient. Alasdair MacIntyre, according to Hauerwas, suggests that the contractual model is a result of loss of community. The contracts are “the moral substitutes for modern society’s lack of shared moral tradition” (Hauerwas, 52). MacIntyre, whose work *After Virtue* described the extent to which modern morality is severed from its philosophical and theological roots, believes that the moral disarray of the modern world means that no one can trust the judgement of another as no one knows what values the other holds. In an earlier work he said “we are thrust back by our social conditions into a form of moral autonomy” (MacIntyre, 1977, 197, 210 cited in Darvall, 1993, 16). Some have tried to resolve these problems in conventional medicine by demanding more “autonomy” for patients so as to protect physicians and patients from each other (Hauerwas, 53).

Alternative medicine is popular partly because people are no longer sure what to expect from their physicians. Is the relationship fiduciary, contractual, a covenant, a partnership? Some find the relationship coldly contractual and turn to alternatives which are perceived to be more caring and humane. In turning to some alternatives, people may be turning to the older, and now generally reviled, paternalistic model of healthcare. Could it be that many sick people are tired of being told that they should grow up and become autonomous and responsible for themselves? Has the defence of autonomy been used by physicians as a cloak to conceal a weariness with caring for the weak? Perhaps autonomy goes hand in hand with a conventional system that is so strained that it can offer nothing beyond basic physical treatment.

Michael H. Cohen says that “some view informed consent as a poor substitute for well-formed agreements between parties and argue that the doctrine [of informed consent]

should not be extended beyond biomedicine and biomedical choices.” He suggests a structure in which healer and client work more contractually in a way which, he thinks, could “expand treatment choices to include complementary and alternative medicine.” He raises the issue of whether law tied to a biomedical model should be applied to forms of healing developed outside the framework of biomedicine (Cohen, 1998, 62).

It is possible that out of these debates will emerge a new medical partnership, applicable in the alternative and conventional field. This partnership would be neither covenant nor contract but a respectful alliance.

Balancing Autonomy and Beneficence

According to Cohen, the current dominant position of biomedicine is inherently paternalistic. It views all aspects of health care “through the lens of biomedical orthodoxy.” All tensions and dilemmas -- whether in medical insurance, law, bioethics -- are based on what are seen to be immutable and objective measures of correct behaviour in the medical field. This assumed superiority is challenged by those who attempt to integrate complementary and alternative medicine with biomedicine (Cohen, 1998, 114-115).

Paternalism is antithetical to an ethic of freedom and autonomy. Engelhardt sees the medical practitioner as a mediator, offering advice on specific choices without putting forth his or her own preference (Engelhard, 1986 in Darvall, 1993, 16). Some physicians believe that honouring the patient’s autonomy means that they must offer the patient a a wide range of choices, presented in a neutral tone of voice. It is then up to the patient to make a final, unguided decision. This practice has evolved as patients have become more litigious. If a physician simply offers choices rather than making recommendations, then she cannot be blamed, or sued, if the outcome is poor (Quill and Brody, 1996, 764). The problem with this

model is that the physician can come to be seen simply as the provider of value-free goods. The professional model of medicine obliges the physician to exercise judgement and to tell the patient what he or she thinks is best.

The relationship of autonomy to beneficence is, in practice, a delicate balancing act.

A practitioner who acts as a technician, merely acceding to the patient's wishes, has abdicated his or her healing role. Stone and Matthews also point to the belief that healing is enhanced by the patient's confidence in the doctor, agreeing that this would appear to be the case, though unproven (Stone and Matthews, 267).

Timothy Quill and Howard Brody believe that physicians can use their power effectively for patients without compromising patient autonomy. They propose an "enhanced autonomy" approach rather than an "independent choice" model of decision-making in which the physician should be a resource for decision-making (Quill and Brody, 1996, 765).

Autonomous choice is "usually enhanced rather than undermined by the input and support of a well-informed physician." Quill and Brody (citing Senge, 1990) recommend dialogue, which includes "active listening, honest sharing of perspectives, suspension of judgment, and genuine concern about the patient's best interests" (Quill and Brody, 765). This is an improvement over the "independent choice" model which views patient autonomy as giving power to patients and taking power from physicians (Quill and Brody, 1990, 765). It shares with Katz' conversation model a belief that the physician-patient relationship is an alliance.

Threats To Autonomy in Complementary and Alternative Medicine: Coercion and Shared beliefs

The patients' rights movement and legal developments since the 1950's have given paternalism a bad reputation in conventional medical practice. However it may still flourish

in complementary and alternative practice. In this field, the dangers of beneficence are greater for two reasons: the practitioner may have an almost religious belief that “her” system of care is the solution to a client’s problem and the client may share this quasi-religious trust in the almost mystical power of the healer. The practitioner described in the introduction to this chapter may fall within this model. Paternalism masquerading as beneficence is no longer justifiable, particularly in the non-emergency setting of most complementary and alternative practices. However, as Stone and Matthews emphasize, not all alternative therapists respect autonomy. Founders of new therapies can act like gurus, demanding “unquestioned respect” (Stone and Matthews, 1996, 266).

Robert Buckman, MD, points out that alternative practitioners usually have one overarching explanation for illness or disease and these explanations are profoundly satisfying to the patient. The conventional doctor speaks in terms of unknowns or scientific probabilities (“we don’t know the cause and the literature says you have a fifteen percent chance of survival with chemotherapy”) leaving the patient wondering if the doctor is competent at all. Many say “if he is a doctor, why doesn’t he know?” The alternative practitioner can sound much more sure of herself (see Buckman, 1993, 94-95; 100-103; 77).

This confidence might, in itself, inspire the patient. Cooperating with a positive thinking practitioner may help the patient to draw on inner healing resources and the patient will either get better or die in a more accepting frame of mind.

The greatest difficulty in ensuring that consent to alternative medical treatment is informed lies in the fact that practitioner and client may share a belief system. While this may also be true of biomedicine, religious or spiritual forms of alternative medicine, particularly those offered by religious denominations (like Christian Science) may pose particular difficulties

for informed consent.

Fortunately for the psychotherapist described in the introduction to this paper, her professional training may have made her acutely aware of serious *lacunae* in her practitioner's approach. She was told to trust, but did not. He was so lacking in persuasive skills that she was unable to share his belief system.

The fiduciary principle is important in any discussion of informed consent. It identifies the obligations of the professional to the client and prevents the professional from exploiting the client. Battin argues that this principle says that the practices and doctrines employed by religious professionals (substitute here alternative medical professionals) must meet secular (substitute here conventional) ethical criteria if the individual participates to advance his self-interest (Battin, 1990, 121, 122).

Battin's point is that people will engage in high risk behaviors if coerced (especially if the treatment takes place in a group); if their risk styles are altered because leaders of the group point them towards one choice rather than another; if their "risk budgets" are altered. For instance, some Christian scientists believe that risk of death from acute appendicitis treated with Christian Science prayer is lower than society in general would believe it to be (Battin, 1990, 94). All members of the group share this perception. Hence the Christian Science perception of health and illness is different from that of conventional society. This belief is supported by testimonials rather than scientific data (Battin, 95-100, 123, 116). The practitioner in the case described in the introduction, in answer to the question as to whether or not the tinctures worked, responded that anecdotes told him they did (anecdotal evidence) and said his teacher especially recommended one (authority). This method of persuasion (not information) was spectacularly unsuccessful with a professionally-trained client who

did not trust him. It might have been effective if he represented a group of which the client was a member. Battin suggests that belief in Christian Science's healing power would be unlikely to survive if those who used its healing system were presented with hard data (Battin, 96). What Battin seems not to recognize is that believers can be singularly impervious to hard data which contradict cherished beliefs.

If, as Brody suggests, patients seek information out of a need for a respectful relationship with their doctors rather than a need for exhaustive detail (Brody, 1992, 89), they may consider details unimportant when meeting with a practitioner in whom they already have confidence or with whom they share a belief. One might also suggest that modern medicine, when it loses its "magic", fails the patient because it denies the need for a religious type of hope in a mysterious but efficacious remedy. The doctor who overloads a patient with information so as to guarantee genuinely informed consent might, at least from the point of view of the alternative medical community, inhibit the patient's innate healing powers.

Conclusion

The challenge for those attempting to devise a code to ensure that the doctrine of informed consent is honoured in complementary and alternative medicine is to find a way to mediate between two different conceptions of reality. While some have argued that practices from the field of conventional medicine cannot be applied to alternative medicine because each operate according to different paradigms, others believe this claim to be greatly exaggerated. Ethicists are, perhaps, in a position to build a bridge between the two types of medical practice. While some argue that alternative medicine so strongly appeals to belief that its efficacy might be destroyed if too much information is given to the client, it ought to be remembered that belief plays an important role in conventional treatment. Minimum standards of what information to disclose can be devised for most types of alternative

practice.

Guidelines to help complementary and alternative practitioners obtain truly informed consent might be helpful. These should include a requirement on the part of the practitioner to state what she is going to do; the purpose of the proposed intervention; the likely outcomes; risks and benefits; information on what the outcome might be if the patient delays or refuses treatment; any alternatives, including those available in conventional medicine; cost of therapy and payment plans.

Ultimately clients and patients are protected when their practitioner and/or physician is herself a person of moral integrity. Laws and codes of ethics are necessary but not sufficient. Conventional medicine prides itself on being able to ensure that breaches of normative errors are few. The physician who makes a small mistake is not judged as harshly as one who demonstrates a cavalier disregard for the well-being of his patients. When Charles Bosk studied the surgical training program of “Pacific Hospital” he discovered a hierarchy of “sins” within the conventional system as well a mechanism for forgiveness (Bosk, 1979). Alternative practitioners and clients often claim that conventional medicine has lost its “soul” because the rigidity of the training and the hierarchical structure of conventional medicine discourage a subjective and compassionate approach to the patient. However, the rigid structure of conventional medical training also serves to protect patients. Far from lacking compassion and concern, conventional medicine punishes precisely those faults that demonstrate lack of genuine concern. Genuine concern includes the desire that one’s patient understands clearly what is proposed and receives the best care possible. Can we say of alternative medicine that its practitioners not only *feel* care and concern but have the training and competence to deliver good care? This will be the topic of Chapter ten which will discuss the training of alternative practitioners. Meanwhile the next

chapter will look at a major issue in the field of complementary and alternative medicine: the safety and efficacy of its products and treatments.

Chapter Eight

Non-Maleficence and Beneficence - Safety, Efficacy and Ethical Research in Complementary and Alternative Medicine

Introduction: Non-Maleficence, Beneficence and Research as an Ethical Obligation

The most contentious issue in the field of complementary and alternative medicine is that of the efficacy and safety of alternative products and practices. Since the 1970's, the demand for evidence-based medicine has increased. Much, though not all, of the treatments in conventional medicine are based on the results of the randomized, controlled, frequently double-blind clinical trial (RCT).⁸⁶ This type of trial is often referred to as the gold standard and has been established for about fifty years.⁸⁷ Now many physicians are demanding that any alternative product or practice be first proven in clinical trials.

Most alternative and complementary practitioners, like most professionals in the conventional medical field, claim to be inspired by the desire to help and benefit others. It

⁸⁶In a randomized, controlled, double-blind drug trial, two groups of patients are selected at random and each group receives what appears to be an identical treatment. Both groups are informed that they may be receiving a placebo or another type of medication and not the medication being tested, but they do not know which "arm" of the trial they are on. Only when the trial is complete is the metaphorical blind removed. Trials of procedures may be conducted, but often cannot be blinded. When mastectomy was considered to be the treatment of choice for breast cancer, some women were entered into a trial comparing this radical treatment with the less-mutilating lumpectomy and radiation treatment. After many years, it was proven that, in many cases, breast cancer need not be treated with a radical mastectomy. On a minor note, out of sensitivity to their patients, ophthalmologists offer patients "double-masked", not "double-blind" clinical research studies.

⁸⁷Interestingly, randomization and the blinding of trials were accepted by conventional physicians after scientists had used these methods to disprove mesmerism and psychic healing (Kaptchuk, 1998, cited in Linde and Jonas, 1999, 59).

would be extremely rare to find a health-care professional who wished actively to do harm. Yet treatments in both the conventional and alternative field of medicine can have deleterious effects. Some may be an unavoidable result of the patient's disease; others due to misdiagnosis of the problem or misapplication of the the remedy. Conventional medicine has a well-established system to ensure that physicians are trained and that products and treatments are tested. Safety and efficacy, therefore, though important issues in conventional medicine, are understood to be taken care of by the many regulatory structures that govern the practice of biomedicine. The same cannot be said of complementary and alternative medicine. The practitioner of an alternative may be driven by only the highest and most altruistic of motives but if she is poorly trained, or prescribes an unlicensed and unproven remedy, then she may harm her client in spite of her beneficent motives. Good will and a pure heart are very desirable virtues in any type of health care professional. But they are not sufficient. The primary duty of anyone who claims to heal or cure is not to harm.

The issues of government control and professional licencing and training will be discussed in chapters nine and ten. The focus of this chapter will be on whether and how the standards of biomedical research can be applied to alternative products and procedures, ways in which appropriate studies can be designed and conducted and the specific risks and benefits of alternative modalities. It will conclude by applying the Canadian *Tri-Council Policy Statement* on ethical research to the specific practices of complementary and alternative medicine.

While modern medical practice is largely based on the findings of research, many types of complementary and alternative techniques are based on historical tradition (some people say "surely if it has been used for hundreds of years it must be safe") or on intuitive notions. Some take this to mean that complementary and alternative medicine not only cannot be

tested according to the norms of conventional research but should not be. This is the issue of incompatible discourse. This chapter will argue that treatments intended to be applied to human beings should be tested or monitored to see if they are safe and effective. Intuitions about effectiveness are insufficient guarantees. The usual way to measure whether a practice is safe and efficacious is through clinical research. Research is undertaken to honour the ethical principle of non-maleficence and the less binding, but nonetheless highly valuable duty of beneficence.

Howard Brody and his coauthors Janis M. Rygwelski and Michael D. Fetters argue that it is unethical for complementary practitioners as a group not to use all research opportunities available and to be open about results (Brody, Rygwelski and Fetters, 1999, 53). Research therefore could be seen not only as a primary obligation under the requirement of non-maleficence but a *prima facie* duty if one is to seek the well-being of society's members. While some might see this demand as one of the many ways in which conventional medicine is trying to control the practice of alternative medicine by calling the shots on what is, and what is not, an acceptable way of measuring how well something works and how safe it is, all practices which attempt to heal and cure may pose risks. The very nature of illness, with its fears of death or disability, renders the patient/client vulnerable. This is as true for users of alternative medicine as it is for those of biomedicine. Wayne B. Jonas, former director of the Office of Alternative Medicine of the NIH, says that to ask " 'is complementary medicine safe?' is no more useful than to ask " 'is medicine safe?'" Neither is inherently safe as people do not normally undergo treatment unless they are suffering from disease (Jonas, 1996, 128).⁸⁸

⁸⁸Jonas does not mention the greater and smaller risks which might impair the healthy who use alternative medicine in the hope of achieving a superior state of wellness. Healthy people can become ill by taking supplements to give them more energy. For example, Ginkgo Biloba, taken to enhance memory, can increase bleeding rates, and

Before turning to a discussion of incompatible discourse between the two fields of complementary and alternative medicine and biomedicine, a short history will place this topic in context.

History of Medical Research

Research ethics is grounded in the values of the *Universal Declaration of Human Rights* (1948) which emphasizes respect for the dignity and equality of the person and the protection of liberty and privacy. Research in North America and Western Europe has long been guided by the *Nuremberg Code* (1947) and the *Declaration of Helsinki*. After the Nuremberg Trials following World War II, and the discovery of atrocities committed in the name of medical research, the values of the *Nuremberg Code*, which emphasized the importance of “voluntary informed consent”, came to guide all clinical research.^{89 90} The World Medical Association *Declaration of Helsinki* (1964, 1975, 1983, 1989, 1996, 2000) was created to fill in the gaps in the *Nuremberg Code* which necessarily focused heavily on informed consent. It formed the basis of many subsequent codes and guidelines. In the United States, the *Belmont Report* was published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Most recently, the three major research funding organizations in Canada, the Medical Research Council,

important consideration for anyone preparing for surgery.

⁸⁹The Nuremberg Code was developed for the Nuremberg Military Tribunal as a measure against which the Nazi experiments were judged and found wanting (McGill University Ethical and Legal Aspects of Research Involving Human Subjects Conducted in the Faculty of Medicine and Affiliated Hospitals. Policies and Procedures, 1993, The Faculty of Medicine, McGill University, 1993, 5).

⁹⁰Codes, however, do not necessarily protect. For example, the German Minister of the Interior issued ethical guidelines for researchers in 1931 (MRC, 1987, 5).

the Natural Science and Engineering Research Council of Canada and the Social Science and Humanities Research Council of Canada, formed what is called the Tri-Council and joined to issue a policy for researchers. It was published in August 1998 under the title *The Tri-Council Policy Statement -- Ethical Conduct for Research Involving Humans* (see Emmanuel, Wendler and Grady, 2000, May 24/31, 2702).

Before the 1940's, research tended to be guided by what the 1987 Medical Research Council of Canada guidelines called "benevolent paternalism". The individual investigator relied on his or her personal ethics. Some early experiments led to important discoveries. Edward Jenner, in 1796, created the smallpox vaccine by inoculating a healthy eight-year-old boy. In 1900, scientists made improvements in the prevention of yellow fever by deliberately infecting volunteers with yellow fever to study how disease was transmitted via mosquitos (MRC, 1987, 3). Neither of these experiments conform to modern standards of research ethics. Furthermore, in the history of research, the poor and disadvantaged were disproportionately experimented upon. The infamous Tuskegee Syphilis experiments submitted African American men, over a 40-year period, to a study of the effects of untreated syphilis without their informed consent and with the coercive promise of special privileges if they signed up. This study might have been partly acceptable before the discovery of penicillin. Once penicillin was proven to cure syphilis, these men continued, untreated, and the trial was officially approved even in 1969, long after penicillin had been proven effective (MRC, 1987, 5). It was in response to this and other abuses that the *Belmont Report* was written (Emmanuel, Wendler and Grady, 2000, May 24/31, 2702). Among many other ethical values compromised in this study, refusing to treat once a cure had been discovered contravened an important principle of ethical research: if a treatment exists, it is unethical to deprive a patient of it for the sake of research.

Research and Incompatible Discourse

At first glance, it might seem a simple matter to simply apply biomedical methods to alternative products and techniques. But, before discussing justifications for and appropriate design of research studies in alternative products and methods, it should be pointed out that some people believe that alternative medical products and techniques cannot, and often should not, be studied.

Some think that the requirement that alternative medicine be tested scientifically before it is accepted is based on a political agenda. Fulder, for example, argues that orthodox medicine's requirement that alternative medicine prove itself scientifically "collapsed" with the acceptance of chiropractic for state registration in the UK. Chiropractic was recognized with only one accepted clinical trial. This, he says, proves that the demand for scientific evidence is more about preserving "existing professional boundaries" than "science" (Fulder, 1996, 20). Fulder believes that it may be too difficult to research treatment that does not conform to the accepted standards of medical science. He argues that the reductionism of modern research is inappropriate when applied to alternative medicine because in alternative medical practice the therapist usually provides each patient with an environment uniquely suited to his or her needs (Fulder, 1996, 22). Fulder examined studies of Chinese herbal medicine which used Western double-blind, controlled research methodology. He says that the researchers lost the "theoretical and practical basis of oriental medicine" by using a standardized herbal mixture; ignored the importance of the therapist by blinding the study; bypassed the fact that Chinese medicine can be used for many diseases by restricting the study only to patients with eczema; lost any measure of the safety and effectiveness of the drug by isolating its active ingredient. He concludes that such research may result in the discovery of a pharmaceutical remedy that will be applied as "a single powerful and toxic new Western drug 'discovery'" with very narrow application (Fulder, 23). Nonetheless,

that very narrow application may be of value to eczema sufferers.

Ruth West points to other types of problems in alternative medical research: many practitioners refuse to perform the initial animal studies so common to conventional medicine. Other therapists claim one cannot separate therapist and patient as the therapist is part of the treatment (West, 1984/1992, 207-208)

Fulder thinks that “fundamental methodological problems arise when one uses the “observational methods based on one culture and world view to [observe] practices that are based on radically different world views” (Fulder, 1996, 24). He recommends that qualitative research methods, particularly those used by anthropologists, would be more effective. “The imposition of these [quantitative] methods on alternative medicine could be a form of ‘epistemological aggression’” (Fulder, 26). Some might see the demand for quantitative research on alternative medical products and procedures as biomedicine forcing alternative medicine to conform to the dominant medical model and plundering the myriad forms of alternative medicine for techniques and products that can be proved safe and effective. However, fair-minded people in both forms of medicine would not view the search for new and effective treatments as competition but as science’s time-honoured search for ways to alleviate suffering.

Fulder is operating from the view that one cannot use the paradigms of one system to analyze another. He joins other authors who believe that different methodologies are needed for different paradigms. Meredith McGuire claims that the dominant biomedical enterprise promoted the idea of biomedicine as the only “true” medicine. She argues that this position means that we cannot use the paradigm of biomedicine to explain other paradigms although the comparison may be useful as a legitimating device (McGuire, 1988,

5). St. George said that complementary medicine should no longer need to “obtain legitimacy from orthodox medicine by adopting its paradigm and research methods” but should take a new paradigm (St. George, 1994, a and b cited in Vickers, 1996, 9). “The belief that research methods are paradigm-specific is also implicit in statements which seem to call for complementary medicine to abandon conventional research techniques” (Vickers, 9). Yet those who cling to the belief in paradigm-specific research will actually go outside the paradigm to support their claims, citing scientific literature from the field of psychoneuroimmunology, for example, to support their claims (Vickers, 11).

The term paradigm, introduced in 1962 by Thomas Kuhn in *The Structure of Scientific Revolutions*, is no longer used in the philosophy of science according to Vickers (Vickers, 1996, 2). Andrew Vickers, who is the director of Information Service, The Research Council for Complementary Medicine, London, UK, finds it interesting that as this concept has become outdated in the field in which it was originally used, it has come to play a central role in discussions about alternative medical research. He feels the concept made it difficult to be clear about research in complementary medicine because of the use of “esoteric” language (Vickers, 1-4).

The idea of the paradigm is often put forward as if it speaks for itself. The Office of Alternative Medicine (now the National Center for Complementary and Alternative Medicine) used the following definition of paradigm: It is “an overarching cosmological conceptual scheme” which “tells whole societies in whole historical periods how to think about...big issues.” This is contrasted with an explanatory model, which is “the way one discipline, denomination or health care system explains itself -- the details of its assumptions, logic and rationale” (Chantilly Report, OAM, 1994, cited in Vickers, 1996, 4-5). Some claim that we are not aware of paradigms but are of explanatory models. Hence

explanatory models can be discussed and changed; paradigmatic models cannot. Vickers claims that the very meaning of paradigm “remains impenetrable” (Vickers, 1996, 4-5).

Vickers says that to acknowledge the existence of paradigms seems, on the surface, to be an acknowledgement that there are different ways of seeing which all should respect. The concept is frequently used to “demonstrate the impossibility of discourse” (Vickers, 1996, 5). Vickers believes that the idea that complementary and conventional medicine have different paradigms is “deeply flawed”. It assumes that medical systems are heterogeneous -- that alternative medicine “is all one thing and conventional medicine is all something different” (Vickers, 7). This flies in the face of the diversity to be found both in conventional and alternative medicine. For example, Coulter (1990) asked if chiropractic was a “‘sub-paradigm’ of naturopathy” (Coulter in Vickers, 7).

According to Vickers, a number of themes can be found among those who use the concept of paradigms. First, they put forward the idea that paradigms exist. Then they state that two separate paradigms govern orthodox and alternative medicine. Since it is believed that research methods are “paradigm specific”, those who hold this view state that the research methodology used in biomedicine cannot be used in alternative medicine and those working within a paradigm cannot see beyond it. Therefore, it is deduced, biomedical researchers cannot “see” certain types of “healing phenomenon”. The person putting forward this argument will say that “the current medical paradigm is outdated and is about to be replaced” (Vickers, 1996, 3). Vickers states that those who use this argument believe that it is meritorious to discard the outdated paradigm of biomedicine because it is a tool of oppression with deleterious effects on health and society (Vicker, 3). This claim, Vickers says, “provide[s] further evidence that the notion of a paradigm is a tool against discourse”(Vickers, 13).

Those who believe in paradigm-specific research hold that clinical trials cannot test the “‘subtle’ effects of ‘holistic’ medicine” (Patel, 1987, in Resch and Ernst, 1996, 26).

Resch and Ernst state that every patient has the right to receive treatment that offers a chance of cure or alleviation of symptoms. “Therefore, if effects are ‘too subtle’ to be recognizable (e.g. through using quality of life, well-being, or patient preference as outcome measures), can they honestly be considered relevant?” (Resch and Ernst, 26).

Some literature promoting complementary and alternative medicine tends to caricature biomedicine, overstating the case for biomedicine’s supposed mechanistic, rationalistic view of the body as machine. Yet do nurses, psychologists and hospice workers treat the body as a mechanical engineering problem, Vickers asks (Vickers, 1996, 7)? Biomedical research, in contrast to those who claim it is only interested in objectivity, *is* interested in the subjective perceptions of the patient. Many trials have been conducted which study subjective states such as pain and anxiety (Vickers, 8). Anesthesia departments, for example, frequently design studies on post-operative pain.

Kuhn introduced his paradigm “to explain scientific, not medical, change”. Health care and science are not the same thing. While one cannot have “both Aristotelian and Gallilean cosmology” at the same time, several paradigms functioning side by side (in interdisciplinary teams, for example) are desirable in health care. The view that paradigms can only exist one at a time and that the current biomedical paradigm should be replaced is extreme and is part of a New Age view that holds that humankind is moving to a higher and purer level of reality, discarding the Cartesian biomechanistic universe which is the legacy of the Enlightenment. There is no evidence of a shift in world views, Vickers says. If there were, then we would see millions of dollars poured into new types of research and the

classical randomized clinical trials abandoned (Vickers, 1996, 11-12). "There appears to be an inverse correlation between discussion of paradigms and the production of useful research results and practical ideas on methodology" (Vickers, 15).

Complementary and alternative medical practitioners who use the concept of incompatible discourse as a way to avoid closely questioning the efficacy and safety of their therapies dishonour the obligations imposed by the principle of non-maleficence. They may claim that their clients are not concerned about such matters but their resistance might cloak self-interest. If one's practices or prescriptions are proved to be worthless, can one honestly maintain that one is serving the good of the public. It takes courage, in the conventional as well as in the alternative field, to allow oneself to be proved wrong, especially if one's livelihood depends on the treatments offered to the public. The history of medicine is littered with the detritus of treatment methods later proved to be either excessive or worthless: radical mastectomy for non-metastatic breast cancer; lobotomies for certain types of psychiatric illness; even a bread and milk diet for ulcers. Complementary and alternative medicine needs to question its methods with the same scrutiny as conventional science.

How then might research in complementary and alternative medicine be conducted?

Research in Medicine: Testing for Efficacy and Safety

When a drug is launched on the market it can be prescribed by physicians and patients may claim a reimbursement from their insurance companies. A successfully completed clinical trial gives a large measure of assurance that the drug will perform as promised and that adverse effects are not so extreme as to nullify any benefit to the patient. However, it is important to note that not every product and procedure needs to be submitted to the rigours of a clinical research trial. Other methods, to be discussed in the section on designing tests of complementary and alternative medicine, can be used. In alternative medicine, acupuncture was accepted without convincing evidence from randomized trials. A National Institutes of Health panel concluded that it helps some conditions and should become a part of conventional medical treatment. Studies have shown it to be effective only for postoperative and chemotherapy-induced nausea and vomiting, and acute dental extraction pain. Nonetheless, the NIH panel recommended it with less evidence than they might require of high-risk interventions because of its increasing acceptance by patients, physicians and insurance companies (Linde and Jonas, 1999, 65).

A number of methods are available to test products and procedures for efficacy and safety. The following is a presentation of some of them:

Testing for efficacy

Kaptchuk, Edwards and Eisenberg offer three theoretical perspectives on efficacy in alternative medicine and discuss a fourth perspective. They look at (1) the model of fastidious efficacy, a term applied to the classical type of randomized clinical trial developed after World War II (the fastidious model uses double-blind studies with a control group to look beyond the placebo effect for the specific effect); (2) pragmatic efficacy, which “compares two treatments under conditions in which they would be applied in practice.”

Here the emphasis is on getting enough information to make a “clinical decision.” The third perspective, (3) performative efficacy, is taken from Tambiah (1990) and the field of anthropology. It “accepts symbols, belief, suggestion, expectation and persuasion as central to illness and health” and is therefore more suited to the qualitative research methods of the social sciences or to patient satisfaction surveys, Kaptchuk and his colleagues say.

Performative efficacy as a research approach requires the researcher to look at the words and rituals that generate feelings of empowerment in the client and requires the client’s faith and trust. It is not an objective research method but measures only what the client believes to be effective. (Kaptchuk, Edwards and Eisenberg, 1996, 43-45).

Kaptchuk, Edwards and Eisenberg’s proposed fourth perspective is based on the work of the eighteenth century mathematician Thomas Bayes (b.1701-d.1761). This is an approach based on Bayes’ early statistical work which “incorporates prior beliefs expressed as probabilities and clinical information into the question of evaluating results from studies” (Kaptchuk, Edwards and Eisenberg, 1996, 62). “The subjectivity of prior beliefs in the Bayesian approach is not a liability, but rather explicitly allows different opinions to be formally expressed and evaluated” (Brophy and Joseph, 1995, in Kaptchuk, Edwards and Eisenberg, 62). The approach has its problems, however. For example, how does one adequately quantify prior beliefs (Kaptchuk, Edwards and Eisenberg, 63)?

Fastidious studies are problematic in trials of alternative medicine in which researchers are unable to collaborate with alternative practitioners and may not fully understand the concepts on which the practice is based. Furthermore, many illnesses treated by alternative medicine are notoriously difficult to study in fastidious trials. Chronic illnesses such as chronic fatigue syndrome have subjective features which are not easily amenable to clearcut entry and outcome measures and cannot easily be reproduced and generalized (Kaptchuk,

Edwards and Eisenberg, 1996, 48-51). Performative efficacy cannot be measured by fastidious trials. Randomized clinical trials, in fact, “dispose[s] of ... this dimension of healing” because “commitment, connection and ‘full subjective participation’ are not allowed.” Informed consent, blinding and randomization create barriers to assessing this kind of knowledge. They “neutralize performative efficacy ...[by removing] patient ‘knowledge’, ‘commitment’ and ‘faith’.” Informed consent, for example, can create powerful expectations (Kaptchuk, Edwards and Eisenberg, 58-60). This, however, is hardly unique to complementary and alternative medicine. All researchers need to guard against creating expectation efficacy by presenting the study to the patient in as neutral a tone as humanly possible (see Margolin, Avants and Kleber, 1998, Nov 11, 1627).

Testing for safety

Naturally, not all drugs, even after extensive testing, prove themselves safe or effective. The Thalidomide tragedy of the early 1960’s is a cautionary example of the dangers of blind faith in science. Although it may be an impractical recommendation in specific cases, some people recommend that one take a medication only after it has been marketed for about five years as it is only when a medication is in widespread use that problems will be seen.⁹¹

When Prozac was first marketed for depression, for example, some people appeared to become more agitated and even suicidal. Researchers and physicians are requested to document post-clinical trial adverse effects and send the information to regulatory authorities so that the drug can either be withdrawn or warnings listed in pharmaceutical formularies and on product leaflets.

Scientists have a variety of ways of assessing adverse effects. They may use laboratory

⁹¹These problems are often detected in Phase IV or post-marketing surveillance studies.

screening methods, look at historical evidence, case reports, adverse effects registries, data from poison control centers. Phase I and II trials are used to discover and confirm short term benefits and adverse effects; phase III trials study the relative frequency and the cause of adverse effects and postmarketing surveillance detects adverse effects that are delayed, infrequent or unexpected. Postmarketing surveillance can detect problems but requires large numbers of people to make an accurate assessment (Jonas and Ernst, 1999, 100).

Other safety assessment methods to help the clinician include qualitative research (case studies, patient interviews); laboratory studies; observational studies (outcomes research which may have no comparison groups); meta-analysis, systematic reviews and expert review and evaluation which look at the accuracy of randomized clinical trials; research into the use and impact of drugs and interventions which involves surveying users (Linde and Jonas , 1999, 57-59).

Sometimes, only a clinical trial will provide ultimate proof of safety and efficacy. For example, for years physicians told menopausal women that estrogen replacement therapy would protect against heart disease. However a double-blind, randomized, placebo controlled trial indicated that estrogen may actually make a pre-existing cardiac condition worse. The study, published in the *Annals of Internal Medicine*, studied 2763 postmenopausal women who had coronary heart disease and concluded that postmenopausal estrogen with progestin increases the risk for venous thromboembolism (Grady, Wenger, Herrington et al., 2000, May 2, 689-696 and see Wenger and Knatterud, Research Letters, 2000, July 5).

Jonas and Ernst point out that in spite of extensive safety assessments of conventional medications, serious risks of this type are sometimes discovered after many years, giving as

examples calcium channel blockers and anti-arrythmics used in heart disease. However it is often difficult to determine whether an adverse effect is due to the drug or underlying disease of the patient (Jonas and Ernst, 1999, 99).

Ultimately, the doctor or practitioner prescribing a drug will look at her own experience with patients with similar conditions, ask whether it is plausible that the drug will help the patient, ask whether the patient is likely to take it (be compliant) and can afford it (Linde and Jonas, 1999, 60).

As noted above, not all products need to be tested through clinical trials. If a trial is to be conducted, it needs justification and research is usually only justified in areas of uncertainty. However, the honestly conducted, randomized controlled clinical trial is a highly effective way of ensuring public safety. Physicians who consider using alternative medicine usually ask whether the product or procedure has been tested and what the results are. This, after all, is the focus of conventional medicine. Nonetheless, if a review of case reports, adverse effects registries, poison control centre data and previously conducted clinical trials yields the required information, then an RCT may not need to be conducted unless required by the Health Protection Branch of the Canadian Federal government. It is unethical to submit people to trials of no or little value and to waste research money. Therefore, before research is contemplated, the researcher needs to judge that the product or intervention chosen to be studied is one about which scientists and clinicians are genuinely uncertain as to whether it will be an improvement over what is available. This is what is meant by “clinical uncertainty, or ‘equipoise’”⁹² (Margolin, Avants and Kleber, 1998, 1626). In the field of alternative medicine, Arthur Margolin and his colleagues give as an example of justification

⁹²The term “clinical equipoise” was coined by the late Dr. Benjamin Freedman of McGill University.

for a clinical trial the use of auricular acupuncture as a therapy for cocaine addiction. The justification for the trial is that cocaine addiction is a serious social and individual problem for which few conventional remedies work (Margolin, Avants and Kleber, 1996). In addition to ensuring clinical equipoise, the researcher must set certain parameters: a sample size that is sufficiently large so that valid conclusions may be drawn; clear eligibility criteria; an appropriate control group; length of study, dosage and so on.

Examples of Difficulties in Clinical Research in Complementary and Alternative Medicine

The following are some examples of alternative practices and some of the difficulties that can be encountered in testing for efficacy and safety. These difficulties are often explained as the result of incompatible discourse but methods can be found to study these practices.

Homeopathy

Homeopathy can be difficult to study because, according to Linde and Jonas, the placebo in homeopathy has a different meaning than it does in conventional drug trials. For example, they say, a conventional anti-arrhythmic tested in a placebo-controlled trial will give clear results as the drug has immediately evident biological effects. A homeopathic remedy, given in its greatest dilution, is considered by conventional science to be inactive (in homeopathic theory, the most highly diluted remedies are considered to be the most potent). If the results of a trial show more side effects in those receiving the homeopathic product, then one might assume biological activity where none is supposed to exist (Linde and Jonas, 1999, 66).⁹³

⁹³Such a trial was conducted by Attena (Attena, F, Toscano G, Agozzino E, del Giudice N. A randomized trial in the prevention of influenza-like syndromes by homeopathic treatment. *Rev Epidemiol et Santé Publ* 1995; 43:380-382 cited by Linde and Jonas, 66).

In a homeopathic trial, one is also faced with many variables. Twenty people, all suffering from asthma, are chosen for study. But how does one divide them? Person one loves hot humid rooms, sleeps on her left side and dislikes spicy food; person two likes sea breezes, open doors, sleeps on her back and craves Indian or Thai food; person three loves dry heat, sleeps on her right side and prefers a mixed bland/spicy diet. And so on. Why is this an issue? Because the homeopathic medical history includes a minute analysis of the person's reactions to temperature, likes and dislikes in food, and sleep patterns. Only after these preferences are analyzed is the remedy prescribed. Twenty people with asthma may be prescribed twenty different combinations of remedies, or different doses. A homeopathic trial needs to cast a wide net to recruit suitable subjects so that people in each arm of the trial receive identical products.

An even more fundamental problem with trials of homeopathy is that scientists believe that dilutions beyond what is called Avogadro's number (the number of atoms or molecules in a mole which is 6.02×10^{23}) violate all the laws of nature whereas homeopaths believe that such dilutions can create an effect. The German Society for Pharmacology and Toxicology said in 1993 that research in homeopathy was worthless. Yet 190 controlled clinical trials of homeopathy have been conducted of which 120 were randomized (Linde and Jonas, 1999, 66)

Herbal Remedies

In the same manner, herbal products are difficult to standardize. For example, echinacea is widely used as a remedy for colds. All echinacea plants have active ingredients which appear to boost the immune system. However, different types of echinacea (*angustifolia* versus *purpurea* versus *pallida*) have different concentrations of the active ingredient and

different parts of the plant may be used (leaves, roots or both). Furthermore, even if only one form of echinacea is used, and planted from the same seed, the active ingredients will vary according to the type of soil, amount of water and sun and season of year in which the crop is planted. Its potency will also be affected by the manner in which it is processed. Unlike conventional drugs, which are highly standardized, herbals may not be so predictable. While consumers may hope for a predictable effect from swallowing a pill containing St. John's Wort or echinacea, the potency of the product will vary according to the manufacturer. Some ask whether standardization is important. According to William S. Reynolds, President, Reynolds and Associates, properly trained herbalists working directly with patients can adjust their formulas or products. He describes the herbalist as "the artist" and calls the patient "the canvas". "The herbs are the materials." While he argues that medicine is partly an art, Reynolds claims that standardization helps the practitioner by removing guesswork (Reynolds, presentation at conference *Complementary Medicine in the Mainstream*, conference, Toronto, Ont., November 23, 1998). Others, however, argue that standardization is not important.

Michael Tierra, a licenced acupuncturist and herbal practitioner, points to the fact that traditional herbalists do not use herbs as magic bullets to attack a disease but as a way to help the body heal itself. He contrasts this to phytotherapy, which takes modern drug therapy as its model. Many books, he says, recommend that consumers buy only standardized herbs. He sees this as a misleading marketing tool that will fatten the coffers of those conventional drug manufacturers who have expanded into herbal medicine. Standardized herbal extracts, he says, are of two types: "active constituent extracts and marker extracts". Active constituent extracts isolate the compound believed to be active and then concentrate it beyond the dose found in the plant. This is a phytopharmaceutical and can create side effects that use of the herb would not. In addition, this manipulation robs the

herb of its more global healing power. Marker extracts refer to plants in which “the active biochemical principle is unknown, so a compound characteristic to the plant is used as a ‘marker’.” In ginseng, ginsenosides are the markers and standardized so that a certain percentage in the dose is guaranteed. This can be misleading as the potency of the herb depends on other factors such as growing conditions. The bottle can promise a fixed percentage of ginsenosides but the tonic properties may be weak. Tierra also points out that standardized herbal extracts may be created with the use of hexane, benzene, methylchloride or acetone which are highly toxic solvents hazardous to the environment. Trace elements may remain in the product purchased by the consumer (Tierra, 1999, July/August, 6, 9).

Acupuncture

Arthur Margolin, S. Kelly Avants and Herbert D. Kleber, writing in the *Journal of the American Medical Association*, speak of the importance of creating effective controls in a study of acupuncture. This is not particularly easy. For example, in a placebo-controlled double-blind study of the use of acupuncture in drug addiction, needles might be placed in “sham” points. Traditional Chinese medicine does not believe in placebos or in any “inert” treatment. In Western medical thought, no marker exists to tell researchers what would constitute an “active auricular treatment” or distinguish an active treatment from a control. Other problems arise from nonspecific effects. Drug dependent people who relax in a chair daily for forty minutes may find that relaxation reduces cravings. These are not insuperable obstacles to conducting research but it is important to be aware that such factors can contaminate the study field (Margolin, Avants and Kleber, 1998, 1627).

Available literature on clinical trials of alternative methods and products

In recent years, attempts have been made to collate the worldwide literature on clinical trials of alternative products. Edzard Ernst, for example, is the editor of the quarterly journal

Fact: Focus on Alternative and Complementary Therapies that summarizes and analyzes studies and other information from mainstream medical and pharmaceutical journals and journals of complementary medicine. He is the chair of complementary medicine at Exeter University in the UK. George Lewith, DM, Julian Kenyon, MD and Peter Lewis, BSc produced a guide for general practitioners on the application of various alternative modalities to specific diseases (*Complementary Medicine: an integrated approach*, 1996); Adriane Fugh-Berman, MD published *Alternative Medicine: What Works. A comprehensive easy-to-read review of the scientific evidence. Pro and con* (1997); Wayne B. Jonas, MD and Jeffrey S. Levin, PhD., MPH edited *Essentials of Complementary and Alternative Medicine* (1999) as a guide for the conventional health care practitioner. In addition, a data base of worldwide research trials is available through the *Cochrane Collaboration. Complementary and Alternative Medicine: Challenge and Change* (2000) was produced by Merrijoy Kelner, professor emerita of the University of Toronto, and Beverly Wellman to gather together recent scholarly research in the field of social science and complementary and alternative medicine. Although it does not focus on clinical trials, it includes a section on assessing the evidence base for complementary and alternative medicine.

How Should Tests of Safety and Efficacy be Designed? Choosing Appropriate Research Methods To Overcome Difficulties in Studying Complementary and Alternative Medicine

Some complementary and alternative practitioners believe that, for the reasons described above, complementary and alternative medicine does not easily lend itself to tests conducted according to the research standards of conventional medicine. However, this does not mean that complementary and alternative therapies and products cannot be studied scientifically. The challenge is to find a suitable research design that honours the specific values of the

alternative practice. It is easy to test a product like homeopathy according to the strict guidelines of the RCT. But the results could be misleading. Howard Brody and coauthors Janis M. Rygwelski and Michael D. Fetter say:

It is not sufficient, in our view, for conventional medical scientists to conduct conventional-type research upon complementary practices, and then reject those practices because no conventional basis can be found for them without at least some critical scrutiny of whether the conventional research methods are truly appropriate for evaluating both the complementary approach and the setting in which it is practiced (Brody, Rygwelski and Fetter, 1999, 53).

George Lewith and colleagues point to the fact that while controlled studies of alternative medicine may seem difficult to design, they can and have been performed. Even such problems as how to practice “blind” acupuncture (when the placement of needles in incorrect acupuncture points may have an effect on the patient) are similar to problems faced by researchers of surgical techniques. It is a mistaken view to assume that practices of alternative medicine cannot be evaluated because the many types of alternative medical approaches cannot be fitted into the rigid structure of the randomized, controlled clinical trial, according to the authors. Trials of homeopathy, as noted before, have been conducted. Though some have been poorly designed, this is hardly unique to homeopathy (LeWITH, Kenyon, Lewis, 1996, 14- 20).

Before attempting to study a specific alternative therapy, one needs to create an appropriate research design. First, according to Andrew Vickers, one must ask what question is being asked in research before talking about the appropriateness of research methods. Research design is matched to the question. While certain questions are logical only within one system (he uses as an example the question about what type of needles dissipate *Qi*?), others can be answered by the methods of another system (Vickers, 1996, 14-15).

Resch and Ernst examine research methodologies to see what might work. They

recommend that the researcher begin with qualitative research, which enables one to formulate a hypothesis, followed by quantitative research to test hypotheses and evaluate safety and efficacy of diagnosis and therapy (Resch and Ernst, 1996, 18-19). The authors believe that quantitative research not based in qualitative research is unethical as it exposes patients and volunteers to risks with no benefit or, at the very least, wastes people's time (Resch and Ernst, 20).

As noted before, many types of alternative medicine resist the quantitative measures of conventional medicine. For example Margolin and his colleagues say it is difficult to set up controls for a study when the treatment involves high interaction between client and practitioner (Margolin, Avants and Kleber, 1998, 1626).

Resch and Ernst recommend that one way around methodological problems in alternative medicine research is to focus on outcome parameters. One may not be able to identify "a simple, established, readily 'measurable' physical or biochemical correlate" but "given the right outcome measure even the most holistic approach can be evaluated through randomized controlled trials" (Patel, 1987, Mercer, Long and Smith, 1995 in Resch and Ernst, 1996, 26; Resch and Ernst, 1996, 27). Margolin and his colleagues, using auricular acupuncture studies as a model, suggest an objective outcome measure of the effectiveness of acupuncture in the treatment of cocaine addiction would be urine toxicology screens several times a week. However, they caution, it may be difficult to obtain such clearcut outcome measures for other types of alternative medicine studies (Margolin, Avants and Kleber, 1998, 1626).

Up to this point, it has been taken for granted that research on the safety and efficacy of alternative medicine is needed. Yet some will challenge this, pointing out that long use has

conferred legitimacy and that if dangers existed, we would probably be aware of them by now. This is not necessarily the case. The *Merck Manual*, a medical guide issued to physicians and health care professionals for a little over a hundred years, offered its 1899 version free with the 1999 edition. In it are listed conventional medical remedies that nowadays would attract malpractice suits or the attention of the drug squad. Our very recent ancestors seemed either to accept certain risks (perhaps the remedies conferred benefits that outweighed risks,) did not know how dangerous they were, or had defined as a disease a condition that twenty-first century people would accept as merely a human variation. The manual recommends arsenic for the vomiting of cholera, opium for the delirium of puerperal fever (although morphine, an opium derivative, is used today) and tobacco for nymphomania (*Merck's Manual*, 1899, 181,161,151). Modern society is extremely conscious of risk, partly because of legal precedents but also, perhaps, because modern science has, in fact, removed many of the fatal risks endured by people one hundred years ago.

The Assessment of the Safety of Complementary and Alternative Products and Techniques

The last chapter emphasized the point that informed consent is only possible when risks are disclosed. But what are the risks of alternative medicine? Edzard Ernst points to the fact that the public is keenly aware of adverse reactions to orthodox medical treatments but perceive alternative treatments to be natural and therefore safe. People turn to them hoping to be cured with no side effects. To equate the natural with the harmless, he says, is misleading (Ernst, 1996, 112).

Wayne B. Jonas and Edzard Ernst say that, from a medical point of view, safety is relative. The Food and Drug Administration of the USA says that safety is relative to toxicity,

potential benefit, how it is used (ie. self-prescribed or prescribed and monitored by a professional), how it is monitored, marketed and advertised and the values underlying its correct use (ie what the person administering it hopes and expects to achieve and judges to be of value, or not). Ultimately, judgements of safety are made on a calculation of risk versus benefit (Jonas and Ernst, 1999, 90-91).

The risk-benefit calculation is the key to making decisions about the appropriateness of a remedy or technique. Some therapies have toxic effects but might be safer than their conventional cousins if the benefit is high. For example, hypericum (St. John's Wort) can cause phototoxicity but may be more appropriate for mild depression than conventional anti-depressants according to Jonas and Ernst (Jonas and Ernst 1999, 91).⁹⁴ Conversely, depriving a severely depressed person of a conventional medication by enrolling him or her in a trial of St. John's Wort might tip the balance and create a risk of suicide which obviously exceeds the well-known risks of antidepressants like Prozac or those of Lithium, used for bi-polar disorders (manic depression).

What Can Go Wrong? Risks and Adverse Effects in Medicine

In conventional and alternative medicine, a medication or product can cause mild or serious effects. These are known as adverse effects and can be placed in the following four categories:

Type A -- adverse effects quickly develop right after the beginning of therapy and a large number of users is affected. Jonas and Ernst give as an example dilation of the pupils,

⁹⁴Jonas and Ernst are citing Linde, Ramirez, Mulroa et al. St. John's Wort for Depression -- an overview and meta-analysis of randomized controlled trials in *Br Med J* 1996; 313: 253-258.

palpitations, dry mouth following ingestion of belladonna alkaloids. These reactions are predictable and depend on dose. They can be prevented by reducing the dose (Jonas and Ernst, 1999, 96).

Type B -- this is a reaction that is not caused by the main pharmacological component of a drug or remedy and the reaction is not modified when the dose is reduced. Some of these reactions are caused by genetics or immunological problems. Patients who experienced liver toxicity after using wall germander (*Teucrium chamaedrys*) or chaparral (*Larrea tridentata*) were having type B reactions. The hepatotoxic qualities of chaparral only became evident after about 500 million capsules had been used over a twenty year period. Jonas and Ernst suggest that doctors should be aware of a type B reaction to herbal medicine when trying to diagnose patients with liver disease of unknown origin (Jonas and Ernst, 1999, 97).

Type C -- this is a predictable reaction that can develop during long-term therapy. A product may cause no reaction unless it is used for a year. For example, people who use herbal anthranoid laxatives over a long period of time can develop muscular weakness because of hypokalemia (Jonas and Ernst, 1999, 96).

Type D -- these can be among the most serious reactions to a product but evidence of such effects can be delayed. Both conventional and alternative medicines can cause birth defects (teratogenicity) and cancer. Some herbal products can cause the uterus to contract (oxytotic properties). Jonas and Ernst say that this effect is more readily identified than properties that cause birth defects. This is an important issue because some may believe that herbal products will create a better pregnancy and a better baby (Jonas and Ernst, 1999, 97).

Jonas further classifies adverse effects in alternative medicine into three categories: direct, indirect, and definitional. **Direct adverse effects** may be short term (toxic effects) or long-term (side effects) of a direct physiological or physical intervention. **Indirect adverse effects** occur because of the way therapy is applied or the diagnosis made. They include the effects of mislabelling, misrepresentation, misapplication and misinformation/misdiagnosis. **Definitional adverse effects** are related to the fact that “systems of complementary medicine use completely different diagnostic categories, patient preferences, explanatory models, and outcome values” than conventional medicine. If the practitioner does not make his definitions and descriptions clear to the client, then misunderstanding can create adverse effects when the practice is applied to the patient (Jonas, 1996, 130 and Jonas and Ernst, 1999, 92-95). Also relevant are **consumer-related adverse effects**, and **situational adverse effects** as described by De Smet (De Smet, 1999, 11-113). Following are examples for each category:

Direct adverse effects

These are easy to detect. If a drug or herbal product is given to a person who, within minutes, becomes nauseous, suffers a rapid heartbeat or goes into convulsions, this is a direct adverse effect. If an adverse effect, like occasional rapid heartbeat or mild nausea, continues as long as the person takes the product, this is called a side-effect.

Indirect adverse effects

Mislabelling

Some herbal medicines are falsely authenticated, containing substances other than those stated on the label (Ernst, 1996, 116-117). Some products do not contain substances described on the label; list one herb when several are used; do not list the inclusion of pharmaceutical drugs. The inert substances should be described as individuals can be

allergic to them (this is also true of placebos in conventional research). Some acupuncture needles are marked sterile when the way they are made and packaged does not conform to appropriate quality control standards. Some products are underlabeled. For instance some Ayurvedic medicines have been found to contain arsenic, mercury and lead either because some practitioners believe that these heavy metals are therapeutic (Jonas and Ernst, 1999, 92; Jonas, 1996, 136-137) or because of sloppy manufacture. Some Chinese herbal remedies have been adulterated with prescription drugs (Ernst, 116). Jonas states that different types of practitioners may have conflicting ideas about what is considered of value in a product (Jonas, 137).

Misrepresentation

According to Jonas and Ernst, a manufacturer of a product or a practitioner who claims that an intervention or diagnostic procedure is effective when it isn't can be responsible for creating an adverse effect. Jonas and Ernst point to ineffective herbal remedies for diabetes mellitus or early stage cancer. In benign conditions, diagnosing illness and then offering a cure wastes time and money and increases anxiety. If a serious medical condition exists, misrepresentation leads the patient/client away from interventions that may help. Many illnesses resolve spontaneously without any intervention. If a person is misdiagnosed (either the wrong illness or a non-existent illness is diagnosed), he or she may then take medicines or treatments that in themselves cause harm or that do not cure the real illness (Jonas and Ernst, 1999, 92-93).

Misapplication

Misapplication of remedies that might otherwise be effective occurs when practitioners are poorly trained, impaired or incompetent or fail to properly refer the patient/client to appropriate care (Jonas and Ernst, 1999, 93-94). Jonas suggests that a conventional

practitioner can misapply a therapy when she does not refer a patient to a complementary practitioner or treats a patient with a complementary and alternative therapy in which she is insufficiently trained. For example, some medical doctors are inadequately trained in acupuncture but practice it nonetheless (Jonas, 1996, 134).

Misinformation/misdiagnosis

If a patient is incorrectly or inappropriately diagnosed, an effective therapy may be given for the wrong condition and correctable conditions may go undetected. Jonas and Ernst pay particular attention to systems of complementary and alternative medicine that offer their own diagnostic categories and therapies for the “diseases” diagnosed. For example, iridology claims that disease in the body can be detected from a reading of the iris of the eye. This may then result in unnecessary treatment either for cure or prevention. Both conventional and alternative medicine are vulnerable to using screening and diagnosis to detect non-existent disease (Jonas and Ernst, 1999, 94-95 and see Jonas, 1996, 135). Tests that yield false positive results may also lead to worry and treatment. For example, laboratory errors can lead to false diagnoses of cancer. Compared to the dangers of unnecessary radiation therapy, the risks of unnecessary alternative treatment may be small. Nonetheless, they can potentially waste a patients’ time and money and create a dependency on the practitioner. Most practitioners, one hopes, make their diagnoses on honest assessments drawn from the frame of reference of their own practice. One way to ensure that practitioners are not tempted to make exaggerated or false diagnoses is to ensure that medical tests are done independently so that the diagnostician does not benefit financially. Both in conventional and alternative medicine, the practitioner who has purchased diagnostic equipment, or who charges for diagnostic tests, is more likely to recommend them and more easily tempted to search for a treatable disease.

Indirect Risks

As well as indirect adverse effects, medicine recognizes indirect risks. Patients/clients may suffer serious risks as the indirect effect of a treatment. Jonas and Ernst give as an example life-threatening coma in insulin-dependent diabetics when insulin was replaced with an “ineffective alternative approach.” Less deadly but equally important are the indirect risks taken when a patient uses a complementary and a conventional product at the same time without informing his or her doctor (Jonas and Ernst, 1999, 95-96).

Definitional adverse effects

Many of the assumptions on which complementary and alternative practices are based are at variance with conventional science. How one diagnoses a disease, explains it to the patient and the type of outcome one expects from treatment is based on assumptions about the nature of illness and cure and the meaning of disease. If the practitioner does not clearly explain her diagnosis and treatment goals to the patient, the patient may assume he is suffering from an adverse effect (for example, the aggravation of symptoms in homeopathic treatment or intense emotions in psychic healing) (Jonas and Ernst, 1999, 92, 95) which the practitioner might see as evidence of the healing process.

The different values of alternative medicine raise questions about what is called “model validity”. This describes the validity of the explanatory model used by the practitioner -- in other words how he or she defines the way his practice affects health or brings about a cure and what he or she believes constitutes a cure. According to Jonas, “Model validity” can affect safety and clinical judgement in the following ways: the manner in which the practitioner defines what is in the product and the way it works; how she classifies patients and diagnoses; what outcomes she values; what outcomes the client values. These make up the explanatory model which includes what is important to test (Jonas, 1996, 136). For

example, qualities other than the chemical constituents of a plant are valued in Ayurvedic medicine (Jonas, 1996, 136). Furthermore, in classifying and diagnosing patients, a Western physician might have one single diagnosis for low back pain and a Chinese practitioner, ten (Jonas, 1996, 137). Patients might value outcomes different from that hoped for by the practitioner. Practitioners might see the disease as the patient's opportunity to be guided towards personal and spiritual improvement and some alternative systems have enlightenment as a goal. Not to consider patient values and to respect autonomy means that even the best-trained practitioner can misunderstand what is needed and risk misapplying a treatment (Jonas, 1996, 138-139).

The psychotherapist described at the beginning of the last chapter on informed consent was a woman who sought a cure for noises in her ear which seriously impaired her hearing. The practitioner she consulted (because she had not received the results of conventional medical tests), approached diagnosis and treatment with a melange of seemingly inappropriate diagnostic and therapeutic tests. The model validity could be said to have affected both the safety of the procedures for this client and the clinical judgement of the practitioner. The practitioner did not define the product or explain how it worked but offered only anecdotal evidence, and an appeal to authority, that the tinctures were effective. His diagnosis was unclear. He seemed to arrive at his rather fuzzy diagnosis by using two methods :(a) observation of the spine, and manipulation, both of which would be orthodox were he a chiropractor or osteopath (yet he connects the hearing problem to childhood toilet training) and (b) a type of psychotherapy, regression. He may have thought that her ear was blocked due to psychological blockages. His valued outcomes appeared to be very different from those of his client, who wanted physical cure. The practitioner seemed to want her to delve into her psyche and offer unquestioning trust. He wanted her to go with the process. The outcome valued by the patient was a cure of a physical problem; the practitioner seemed to

put more value on psychological causes. The explanatory model used by this practitioner is ambiguous. He appeared to be using a pot-pourri of techniques borrowed from separate disciplines within the field of complementary and alternative medicine. One suspects, even though he is described as licenced, that he was, perhaps, licenced only to practice one form of alternative medicine. He may be a naturopath with some chiropractic or osteopathic training; a homeopath who has taken a few short courses in spinal manipulation; a chiropractor who has taken short courses in homeopathy and past-life regression.

Consumer-related adverse effects

An individual may suffer an idiosyncratic adverse reaction to a conventional or alternative medication. The problem may be age or disease. De Smet gives as an example those who metabolize the quinolizidine alkaloid sparteine slowly. These people will be more vulnerable to the oxytoxic (causing uterine contractions) potential of a remedy like Scotch Broom (*Cytisus scoparius*), which has been used as a diuretic or laxative, than others. Of particular importance in alternative medicine is the recognition that different races and ethnic groups may react differently to conventional and herbal medicines. For example, the hearts of Chinese people respond more sensitively to atropine than do those of Caucasians. People of African descent respond the least. One can extrapolate from this that a traditional herbal remedy used in one cultural group may be ineffective or dangerous in another (De Smet in Jonas and Levin, Eds., 1999, 111). Tests need to be done that take this into account when listing the exclusion and inclusion criteria for those who are admitted to clinical trials.

Situational adverse effects

Herbal products that are generally safe may become dangerous in certain conditions. Herbal products that produce phototoxic reactions may cause burns if the person using them also visits tanning salons or is a patient undergoing PUVA therapy (a light therapy for

dermatologic conditions). De Smet adds to these risks the danger that an athlete may test positive for drugs in doping tests because the International Olympic Committee's list of doping substances includes several substances, like ephedrines, that are found naturally in herbs (De Smet, 1999, 112).

Examples of Adverse Effects and Risks in Specific Complementary and Alternative Therapies

All therapies, conventional or alternative, should be judged on a risk-benefit ratio in which benefit must exceed risk. Some complementary and alternative products and procedures, like some conventional products and procedures, are overwhelmingly risky; many pose few risks or are benign. In conventional medicine, the major risks of chemotherapy (altered white and red blood cell count, suppression of the immune system, extreme nausea) are considered to outweigh the risks of metastatic cancer. It would be obviously unethical to expose a healthy volunteer to chemotherapeutic agents. It is important to note here that health care providers and patients do not always define risk in the same way. A physician might think Tamoxifen, taken prophylactically by women considered to be at high risk for breast cancer, well worth the risks of the medication. The healthy woman might reject the drug on the grounds that it can create endometrial cancer, which is a serious risk, or on the grounds of the discomfort caused by the drug which might, in her view, outweigh any putative preventive benefits.

In complementary and alternative medicine, a person might choose to undergo spinal manipulation for a mild backache, with its associated risk of stroke, when bedrest might be the safest option. On the other hand, someone who has suffered severe and prolonged back pain which conventional medicine has failed to cure, might be willing to assume the well-known, but usually well-monitored, risks of chiropractic.

Jonas and Ernst note that one cannot assume any practice is inherently safe as safety is based on this risk-benefit calculation (Jonas and Ernst, 1999, 91). To understand what risks they are taking, which is a part of informed consent, the consumer needs knowledge about the action of plants, products and procedures. Jonas and Ernst list herbal medicine at the top of their list of high-risk practices. As many children have been told, the pretty plants growing by the roadside are not to be eaten. Poisoners know what plants can do. While parents and pet-owners are usually aware that certain houseplants can cause anything from diarrhea to death, consumers of herbal products sometimes forget these lessons. Bottled herbal extracts may be safe but, until government regulations become more extensive and stringently enforced, the public must exercise caution because they do not have the protections offered by the better-controlled pharmaceutical industry. Like conventional medicine itself, conventional drugs are hedged around with many regulatory restrictions: they can only be bought on prescription; the pharmacist may only be permitted to dispense small amounts (for example, certain pain killers or anxiolytics are dispensed in lots of twelve to reduce the risk of overdose) or the action of the drug is known and side effects recognized.

As well as herbal medicine, Jonas and Ernst list as high risk practices intravenous hydrogen peroxide or hi-dose megavitamin and mineral infusions, colonics, high-velocity spinal manipulation. Though they list meditation and mind-body techniques such as visualization, psychic or spiritual healing as safe they note that the most benign-appearing therapies cannot automatically be assumed to be safe, suggesting that even prayer can have negative psychic effects (Jonas and Ernst, 1999, 91). Visualization, according to its proponents, can be so powerful as to cause serious damage when the wrong process is imagined

(Achterberg, (1985),⁹⁵ and some Christian writers see grave spiritual dangers in psychic or spiritual healing. Jonas does, however, refer to Larry Dossey's references to adverse effects caused by "'psychic' phenomena" (Dossey, *Journal of Scientific Exploration*, 1994; 8 (1) 73-90, cited in Jonas, 1996, 129).

Ernst focuses on homeopathy, herbalism, acupuncture and spinal manipulation and describes adverse reactions to these treatments.

Homeopathy

Homeopathy is usually referred to as a non-toxic form of medicine. It uses remedies in which a substance is shaken (succussed) in liquid and diluted, sometimes to the point that barely a molecule of the original substance remains (this is considered to be the most powerful dose). Concentrations of dangerous substances that could be toxic can, however, remain in low dilutions (Ernst, 1996, 112-113; Jonas and Ernst, 1999, 91). Ernst cites Kerr and Saryan (1986) who found concentrations of arsenic and De Smet (1992) who found remains of cadmium in homeopathic remedies. Low-potency preparations, according to Ernst, can cause allergies. Given these findings, he suggests that homeopathic remedies

⁹⁵Images of the effect envisaged require a knowledgeable guide. Images and facts must agree, even if symbols are used for facts, Achterberg says (Achterberg, 1985, 106). She gives as an example a patient with rheumatoid arthritis who had learned of cancer patients who imagined that their white blood cells were "white knights." The patient therefore adopted these images, asking "battalions" of white knights to kill her arthritis. Unknown to her, rheumatoid arthritis is an autoimmune disorder in which over-active white blood cells exacerbate the illness (Achterberg, 1985, 106-107). Yet sometimes an image based on a misunderstanding can be helpful. Bernard Lown, introducing Norman Cousins' *The Healing Heart* (1983), spoke of a patient with severe cardiac disease. Walking into the patient's room one morning, the doctor told the staff accompanying him on rounds that the patient's heart had a "wholesome gallop," meaning that the heart was failing. The patient heard this as meaning that his heart had "a lot of kick" and recovered (in Achterberg, 1985, 79).

might interact dangerously with other treatments, just as conventional drugs and herbal preparations do (Ernst, 112-113).

In homeopathic treatment, what is called an “aggravation” of the symptoms in the initial stages of treatment is often viewed as proof that the remedy has been correctly chosen. When treatment causes mild psoriasis to become more troublesome or more extensive, the homeopath sees this as a positive sign. Ernst asks whether these “homeopathic aggravations are a real phenomenon” or whether they are not the result of the natural progression of a disease not “addressed systematically.” If these aggravations are real, he says, they should be viewed as adverse reactions (Ernst, 1996, 113). The concept of the homeopathic aggravation might be interpreted as a system to explain failure similar to those used by faith healers when the patient dies (but was spiritually healed). While scientific data may prove the theory to be grounded in observable phenomenon, in a trial of homeopathy almost as many in the placebo control group reported an aggravation of symptoms. This raises the question of the existence of the phenomenon of aggravation (Jonas and Ernst, 1999, 168).

Reverse effects might also be seen in homeopathic treatment. Jonas and Ernst describe studies that suggest that aspirin, serially agitated in preparation, can cause rather than curtail thrombosis. Homeopathy works on the principle that like cures like. Hence highly dilute concentrations of nicotine might be administered for nausea (nicotine swallowed in a normal dose would cause nausea and possible death). Studies in animals, Jonas and Ernst report, demonstrate that high potency arsenic can speed up the elimination of arsenic “when subsequently given in toxic dose.” Jonas and Ernst ask whether homeopathic products containing essential minerals might similarly cause such nutrients to be eliminated from the body. They point to an even more serious danger, asking whether or not cytotoxic drugs

administered as homeopathic remedies, might cause proliferation of cells and cancer when administered to reverse cancerous cell growth (Jonas and Ernst, 1999, 168-169). Other problems associated with homeopathy include a patient who is slow to respond to the stimulation of her healing powers (a situational adverse event); duration of action of a dose which lasts for up to a year; symptom control but no cure of the underlying disease (which can easily occur in conventional medicine, as well) (Jonas and Ernst, 169).

These adverse reactions may be rare, Ernst says, but considering that under-reporting of adverse events is common in conventional medicine, we might deduce that more clients of alternative medicine suffer from them than report them (Ernst, 1996, 113). This is more likely if those who practice and those who seek out alternative medicine have an almost religious belief in their chosen modality. When belief in a system takes on quasi-religious features, mechanisms to minimize problems and failure are more likely.

Herbal medicine

Herbal medicine is a field in which one can readily see the dangers of toxic reactions. Reports range from skin problems to potentially fatal anaphylactic shock. A number of studies have associated some herbs with acute hepatitis and even cancer (Ernst, 1996, 114-115). But what about those innocent herbs that one grows and extracts oneself? The home herbalist would be well advised to ensure that the extraction methods are sterile and that the concentrations are safe. Some plants have been used for thousands of years and have historical use as a testimonial. Herbal extractions have been used safely by indigenous groups around the world. However, long-standing use is not, in itself, a claim to safety. Extracts made from traditional plants may be extracted non-traditionally, using hexane, a nonpolar solvent, which may affect safety or they may be administered in a non-traditional way (for example, herbal cigarettes) (Jonas and Ernst, 1999, 98).

Acupuncture. Spinal manipulation

The dangers of acupuncture include non-sterile needles (which is, of course, also a risk in doctors and dentists offices), damage to tissues or organs when needles are inserted incorrectly or too deeply. Pneumothorax and haemothorax (in pneumothorax, air enters the pleural space and the lung collapses or the chest wall becomes air tight. In the haemothorax, blood enters the pleural space in the lungs) can occur, as well as allergic reactions (Ernst, 1996, 117-118). With spinal manipulation, the most frequent complications are vascular accidents such as strokes. Other problems associated with spinal manipulation are dislocated vertebrae and fractures in people with osteoarthritis (Ernst, 119-120).

Drug interactions and overdose

One of the most dangerous aspects of alternative medicine might lie in the fact that people using alternatives, according to most surveys, do not tell their doctors. Many simply buy the product over the counter without seeking the counsel of a professional naturopath, herbalist or homeopath. A product might be perfectly effective, taken as instructed on the label, but might be dangerous mixed with other medications. Like conventional medications, it might be safe in tiny doses and fatal in large ones. And it might interact dangerously with conventional medications. Howard Brody and his co-authors suggest that physicians should assume that their patients have consulted an alternative practitioner unless they have information to the contrary (Brody, Rygwelski and Feters, 1999, 50).

This chapter has discussed the necessity for research, the ways in which research studies can be designed and the risks that warrant research. It will conclude by extending the ethical proposals contained in the Canadian Tri-Council policy on research ethics to the field of complementary and alternative medical research.

Ethical Research and Complementary and Alternative Medicine

The *Tri-Council Policy* offers eight ethical principles to guide researchers. The authors believe that they reflect the standards of diverse disciplines in the research community. They are: respect for human dignity; respect for free and informed consent; respect for vulnerable persons; respect for privacy and confidentiality; respect for justice and inclusiveness; balancing harms and benefits; minimizing harm; maximizing benefit (MRC; NSERC; SSHRC, 1998, August, 1.5-1.6). As such, these guidelines closely follow the four principles of autonomy, non-maleficence, beneficence and justice. The following is based upon and extrapolated from the policy (1.5-1.6).

1. Respect for human dignity includes respect for the cultural norms of an individual or society. Applied to complementary and alternative medicine, the basic requirement of this principle, that the many interests of the individual client or patient be respected, can be expanded to include a requirement to treat seriously various culturally or ethnically-based types of alternative medicine by collaborating to create well-designed research studies.

2. Respect for free and informed consent, which was discussed extensively in the previous chapter, is crucial in research where the requirement for consent is usually more stringent. No patient or client should ever feel obliged to participate in a research study. This is a very real danger in biomedicine, when treatment and research (particularly in studies of cancer treatments) are often one and the same. In complementary and alternative medicine, the needs of the client must always be placed before the economic and scientific needs of the researcher. To this end, someone with no scientific or financial interest in the study should obtain the client's informed consent.

3. Respect for vulnerable persons means that special care must be taken when research is proposed among a group of people who are vulnerable because of diminished mental competence, who are institutionalized or imprisoned. These people are known as “captive populations” because they cannot easily refuse for fear of antagonizing their care-givers. Patients in palliative care units are clearly vulnerable and members of a captive population. Given the fact that alternative therapies such as Therapeutic Touch, Reiki and guided visualization are more likely to be practiced in palliative care units than elsewhere in a hospital, and given the likelihood that students and nurses might wish to design research studies incorporating these methods, managers of such services must take great care to ensure patients are not coerced on the grounds that the method “can’t hurt.” Conversely, while the vulnerable should not be exploited, they should not be discriminated against by exclusion from a study if they might benefit. Researchers should avoid the temptation to exclude all those who might pose troublesome issues while at the same time they should create mechanisms to protect vulnerable people. This is usually more of a problem in biomedical research.

4. Respect for privacy and confidentiality means that all research results must be published without identifying those who participated, unless they gave consent. A complementary and alternative medicine researcher may be very proud of a client he successfully healed. He or she should make absolutely sure he has the client’s consent if her name is to be used in testimonials or published works. All references to specific patients should be disguised so that the patient herself would not recognize her case.⁹⁶

⁹⁶Altering case reports to protect confidentiality can, however, cause problems in accurately describing problems and treatment. The gender, race and social conditions of a person might be highly relevant to the success or failure of a particular treatment.

5. Respect for justice and inclusiveness means that the ethics review process should itself be fair and independent. Obviously the research team should not be part of the review committee. The *Tri-Council Policy* also points out that research has both benefits and burdens, and these should be fairly distributed throughout the population. No one group should shoulder the burdens; no one group should exclusively benefit. Questions of justice arise in the funding of research studies. Conventional pharmaceutical companies can afford to finance large clinical trials. Can society find a way to make funds available to study promising forms of alternative medicine, and should it? In the U.S., the National Institutes of Health has made funds available to researchers. Those opposed to alternative medicine argue that this diverts funds from promising treatments to those of no value.

Another issue relating to justice is the paucity of comparative studies between alternative and conventional products or between two alternative products. Some studies have been conducted comparing St. John's Wort to Prozac. Currently, conventional medicine decides what is an acceptable control for the study of an experimental drug. Biomedical research ethics holds that it is unethical to withhold a recognized conventional treatment from a patient for the sake of research, unless the research treatment is believed to be superior to conventional treatment. Consequently, Arthur Margolin, S. Kelly Avants and Herbert D. Kleber only mention studies of an alternative treatment *compared* to a conventional treatment, given as a *supplement* to a conventional treatment or compared to an inactive control only when no conventional treatment exists (Margolin, Avants and Kleber, 1998, 1626). Not all research into alternative medicine will be conducted in the conventional medical setting and may require the collaboration of conventional physicians with alternative practitioners in private practice. However Jonas and Ernst point out that techniques like acupuncture and spinal manipulation have been studied both with and without conventional medicine as a control in a RCT (Jonas and Ernst, 1999, 93).

6. All researchers and those who review their studies must ensure that the benefits to the individual or to society (although this can be slippery if researchers sacrifice an individual for the good of society) outweigh any risks or harms. Research is undertaken in conditions of uncertainty. Nonetheless, scientists can estimate probable risks and benefits and should make sure that patients understand these clearly.

7. One should not accept a patient's signed consent to a very high risk research procedure as a guarantee that one can proceed with impunity. Consent is necessary but not sufficient and no researcher should expose an individual to unwarranted harm, no matter how great the benefit to science. However, in some cases, patient consent is waived: in emergencies in which no standard treatment will work (for example an unconscious person suffering from an antibiotic resistant infection might be a suitable candidate for an experimental drug or an alternative remedy), and in cases where a drug must be tested on its target group (Ginkgo Biloba has been tested on patients with Alzheimer's Disease). Nonetheless, all researchers must do all in their power to limit the harm that a study may cause. This area is one of the thorniest in research ethics. For example, should one expose healthy young volunteers to the risks of a medication or procedure that cannot safely be tested on a sick patient? Among ways to minimize harm is to study only the minimum number of people necessary to achieve a valid result and to do as few extra tests (for example blood drawing, EKG's, x-rays) as possible. This may be less of a problem in complementary and alternative medicine. Nonetheless, risks exist here, not the least of which might be asking a patient to cease taking a necessary medication such as insulin or a cardiac drug.

8. All research studies should be carried out in the spirit of beneficence. The good researcher wants to maximize the benefits, both to the individual client or patient and to

society and science as a whole. Well-conducted clinical trials of complementary and alternative medical products and procedures would go a long way towards benefiting society: proof of safety and efficacy might yield less expensive and less dangerous remedies; individuals who actively choose alternatives would be reassured to know that the product or treatment they choose has been proven efficacious. Physicians might feel more confident in prescribing alternatives. New and better solutions to old problems might be found in such research.

Conclusion: The Current Status of Research in Complementary and Alternative Medicine and Justice and the Allocation of Resources to Alternative Medical Research

Many scientists decry the fact that money that could be used to conduct research into conventional medicine is siphoned into research into unproven remedies that they believe cannot be proved effective (Schwartz, 1996, 28-32). Yet research into herbal remedies and other forms of alternative medicine is crucial if the public is to have any kind of protection. In North America, herbal remedies which people take for conditions as diverse as chronic fatigue to high cholesterol are governed by a patchwork of laws. The hapless consumer has little to rely on other than the good name of the company harvesting and processing the herbs. An author of a book on popular herbal remedies suggests that individuals purchase herbal medicine from well-known companies manufacturing in countries such as Germany or France where quality control of herbals is known to be strict (Carper, 1997, 279). In Germany, all medical doctors are required to study botanical medicine and herbal remedies are manufactured and sold under very strict legislation. In contrast, in North America, the potential consumer of herbal medicine cannot be sure that the remedies available locally are safe, contaminated or mislabelled. In most cases, the consumer is unable to consult his or her doctor as to whether or not the remedy would be helpful. In Europe, such remedies are

often prescribed by conventional physicians. In North America, physicians tend to believe what they were taught and dismiss other cures as magical placebos (see Carper, 1997, 19-29).

Because conventional and alternative medicine occupy such separate universes, patients don't always tell their doctors that they are taking herbal remedies, even though they may interact with conventional medications to ill effect, and many doctors would not know how to respond if patients did tell them. How many people know that Ginkgo Biloba, used not only for people with Alzheimer's disease but ingested over a long period of time by students attempting to enhance their memory, can cause spontaneous bilateral subdural hematomas, and, combined with aspirin, can cause "spontaneous bleeding from the iris into the anterior chamber of the eye" (Rowin J., Lewis SL. Spontaneous bilateral subdural hematomas associated with chronic Ginkgo biloba ingestion. *Neurology* 1996; 46: 1775-1776; Rosenblatt, M, Mindel J. Spontaneous hyphema associated with ingestion of Ginkgo biloba extract. *N Engl J Med* 1997; 336: 1108 cited in De Smet, 1999, 118)? If legislation were in place and doctors trained, the public would be able to choose remedies safely and doctors would have more ways to cure their patients' ills (see Carper, 9-29).

Canadians may become better protected in the future. An advisory Panel on Natural Health Products was set up by Health Canada in May, 1997 and the Standing Committee on Health produced a report, *Natural Health Products: A New Vision*, in November, 1998. In March 1999 the Minister of Health tabled the Government's response to the report *Natural Health Products: A New Vision*. This response agreed with all 53 recommendations of the Standing Committee. At the same time, the Minister announced that he would create the Office of Natural Health Products (ONHP) to assure product safety (Health Canada Information backgrounder, <http://www.hc->

sc.gc.ca/english/archives/releases/1999/9946ebk2.htm). In May 2000 the Office of Natural Health Products announced that it had established an expert advisory committee and suggested that products might be labelled with government-approved health claims by 2001 (Joyce, 2000, May 25, A11).

Chapter Nine

Non-Maleficence and Beneficence - Public Accountability and State Control Of Complementary and Alternative Medicine

Introduction -- The State of Health Care Legislation in Canada

Alternative medical treatments that purport to heal may have the capacity to harm. As interest in and use of complementary and alternative medicine increases, many believe it is irresponsible to leave its practice to market forces. As some conventional physicians and medical institutions move towards incorporating complementary and alternative medicine into their practices, the need for accountability through some form of regulation becomes urgent. Whether or not regulation is important to those practitioners who value their alternativity is an open question. Some may enjoy the increased prestige of association with the medical profession; others may view such association as an unacceptable submission to an already powerful and controlling institution. As one speaker commented at the conference *Complementary and Alternative Therapies in the Academic Medical Center: Issues in Ethics and Policy* (Philadelphia, November 10-12, 1999), many alternative practitioners conduct practices sufficiently lucrative as to render any association with conventional medicine unnecessary and possibly harmful to their interests.

The topic of this chapter is the responsibility of governments to legislate for complementary and alternative medicine. It will examine the role governments may play in regulating alternative medical products and practices. A hierarchy of roles exists for the government to play: the mildest form of regulation is consumer information (some have suggested a government clearing house to disseminate information on alternative products); general

consumer protection laws; specific legislation to control practices like acupuncture and chiropractic; the labeling of alternative products which have been tested for safety and efficacy; regulatory powers delegated to the provinces and provincial health associations; provincial control of professional licencing; regulation of alternative practice in hospitals through hospital and provincial legislation.

Alternative and complementary medicine is largely unregulated -- a situation widely regarded as being dangerous (Stone and Matthews, 1996, 139). But, as Stone and Matthews point out, even when specific forms of alternative medicine are not governed by statute, many are well-regulated on a voluntary level and include codes of ethics and disciplinary procedures within their associations. While conventional health care is governed by law, Stone and Matthews say that the statutory model is not necessarily the correct one to govern alternative therapies in which the relationship between practitioner and patient is very different from the conventional doctor-patient dyad (Stone and Matthews, 1996, 139). Stone and Matthews argue that the statutory model of health care regulation exists because of the enormous power imbalance between the medical profession and patients. The law was designed to protect patients from damage by doctors. The emphasis is on the doctor's obligations, not the patient's responsibilities. This is antithetical to the holistic model (Stone and Matthews, 119, 191).

Even if alternative health care is not governed by statute, the current status of complementary and alternative medicine, much of which is unanswerable to any official group, can pose dangers to the public.⁹⁷ Consequently, the Canadian government is looking at ways in

⁹⁷A CTV/Angus Reid poll conducted in 1997 discovered that 67% of Canadians want the government to regulate alternative medical products and practices to ensure safety and efficacy, just as it regulates conventional medicine (<http://www.angusreid.com/old/pressrel/alternat.htm>. Dec 13, 1999).

which complementary and alternative medicine can be organized so as to protect the public. Protection may take the form of education – an ideal role for Health Canada (York University, 1999, xvii), guidelines or legislation. As interest in alternative medicine increases, the issue of regulation is unavoidable. This chapter and the next will discuss the various forms this regulation may take.

A 1999 report prepared by York University Centre for Health Studies for Strategies and Systems for Health Directorate, Health Promotion and Programs Branch of Health Canada, says that when considering legal regulation, one must first ask “who can make the rules?” (York University, 1999, 89). This chapter will focus on the protection of the public through public and professional guidelines so that those who choose complementary and alternative forms of healing will be protected from harm. Even if no power imbalance exists between alternative practitioners and clients, alternative medicine can injure health. The cry for more regulation is the expression of a fear of harm and the felt need to legislate to prevent harm. This chapter will argue that it is the federal and provincial governments that can and should create legislation to organize a largely unregulated field. It will look at various types and levels of control, related to potential perceived risk. It will also discuss and make proposals for a type of legislation that will protect the autonomy of consumers and alternative health care practitioners.

The perception that huge numbers of people are patronizing alternative health care has led representatives of conventional medicine to see whether or not it can incorporate alternative health care in the conventional medical setting. This is particularly apparent in the United States. While subsuming alternative health care under the conventional umbrella might appear to give it power and dignity, it might also be seen as a way to co-opt alternatives to conventional medicine’s goals. A theme that runs through several articles in a 1999 text-

book on CAMs for conventional doctors and health care practitioners is the desire to instruct one's patients on the best alternatives (see Jonas and Levin, Eds., 1999). While many people would find medical approval of a practice reassuring, it is also possible that some conventional doctors mask the fear of loss of authority with an overconcern with safety, efficacy and regulation. The 1999 report from York University, noting that many patients do not inform their doctors about their use of alternative medicine, deduces that patients may fear that their doctors will react negatively and that "relationships among various disciplines and providers may be strained" (York University, 1999, xvii). The report argues that this lack of coordination leads to "fragmentation of health care" and recommends that health care of all kinds should be coordinated "given how little is known about the interaction between conventional medicine, alternative health care and natural health products..." It recommends that Health Canada set up workshops and other educational programs to help conventional and alternative practitioners communicate with one another and to provide education to the public about therapies and products (York University, xvii). While laudable, one might also ask what is so disturbing about lack of coordination. Interestingly, Québec, the province that controls even the health-care complaint-handling system by law, has so far shown little interest in regulating alternative medicine.

Federal and Provincial Legislation

In Canada, the federal government is responsible for products and devices sold for health care. While the Health Protection Branch of Health Canada, for example, has authority to control herbal remedies and devices used in acupuncture or chiropractic, each province enacts its own legislation to govern what is listed as a health profession and to control professional standards. Each province has the authority to enact legislation that ensures that health professions are self-regulating, creating their own professional standards,

determining who is permitted to practice, who is licenced and registered (Morris, 1996, 44-45). These provincial groups are responsible for continuing education and for disciplinary procedures. In some provinces, special, independent, statutes govern such professions as medicine, physiotherapy, chiropractic, optometry, naturopathy; other provinces have more general legislation governing all health professions with specific legislation for each profession (Morris, 45). Because of the fragmentary nature of Canadian health legislation, a naturopath may be an accepted health professional in one province and not in another. Only chiropractic is regulated in all Canadian provinces and the Yukon (York University, 1999, 133).

The York University authors of the report for Health Canada believe that the federal government occupies an important place in the care of its citizens' health. The *Canada Health Act* governs the Canada-wide Medicare system. Citing the authority of the Constitution Act, which holds the federal government responsible for "Peace, Order, and good Government" (Constitution Act, 1867, (U. K.), ss.91) the report notes that the federal government ensures public safety through such legislation as the *Food and Drugs Act* and the *Hazardous Products Act*. It also points to the power of the federal government to exert its control over health care in the provinces through transfer payments. However, this influence has been attenuated by reductions in those payments. The provincial governments hold primary responsibility for health care. They are responsible for the cost of health care, equitable access and quality of services. In each province, the legislation delegates to the health professionals themselves the power to govern the practice of medicine. These professionals are regulated by licence or certificate (York University, 1999, 89-91, 93).

In recent years, existing regulatory structures have been questioned. Various provincial commissions have moved towards creating omnibus bills to regulate all health professionals

under the same rules. The goal of this sort of legislation is “to act as a levelling influence among the elite, predominantly male health professions such as medicine and dentistry and predominantly female professions such as nursing and dental hygiene that to that point in time had occupied a subordinate status” (Health Professions Legislation Review, *Striking a New Balance: A blueprint for the regulation of Ontario’s health professions*, 1989, Bohnen, *supra* note 41 at 2 in York University, 1999, 95-96). An omnibus bill can regulate professions considered to be alternative.

In Ontario, the *Regulated Health Professions Act, 1991*, was created to regulate 24 professions (as opposed to five under the earlier *Health Disciplines Act*). Linda Bohnen points out that the act has two contradictory goals. It is responsible for ensuring public safety and is to allow consumer choice. Some professions have been officially recognized under the RHPA -- midwifery and chiropractic are two examples (midwifery had not been regulated; chiropractic had been governed by the *Drugless Practitioners Act*). However, Bohnen points out, creating strict legislation to make sure that health care practitioners practice only within carefully drawn boundaries conflicts with the legislation’s other goal -- to create a “competitive market and greater choice” through “deregulation” (Bohnen, 1994, in York University, 1999, 97).

Other changes created by the 1991 legislation include the provision that each self-regulated profession must protect the interests of the public. This is a major change from a past emphasis on serving the profession. The York University report says that the omnibus legislation of Ontario health care professions makes it clear “that the only acceptable justification for this delegation of public power and authority from the state is to protect and promote the public interest” (York University, 1999, 99).

Why Regulation?

Only very recently, alternative medicine was considered by conventional health care professionals to be a highly dubious enterprise. This suspicion still lingers as the researchers who contributed to *Complementary and Alternative Health Practices and Therapies - A Canadian Overview* discovered. An unexpected response to the descriptive study included a request from many respondents that they remain anonymous (York University, 1999, ix). The authors note that many representatives of hospitals and other health care organizations may have been apprehensive about being questioned by the government. They query whether or not the marginal status of alternative medicine has made it difficult for people working in conventional health care to be open about research in this field. Even where interest exists, ignorance abounds. Some information given by those questioned was inaccurate or out of date (York University, 1999, 49-50). The researchers surveyed national and provincial umbrella organizations to see if they had information on any policies or practices governing CAM in the areas for which they were responsible. They found that the respondents had limited awareness of the extent of interest in and use of complementary and alternative medicine and the part it played in their organizations. Hospital, community health clinic and public sector officials likewise had little knowledge of the status of CAM in their organizations (York University, xi). Given this vast level of ignorance, it is not surprising that many consumers continue to withhold from their doctors information about their use of alternative medicine and that doctors fail to ask patients if they are using complementary and alternative products or treatments.

Some doctors still think that use of alternative medicine is of little significance. Dr. Wallace Sampson, Director of the Alternative Medicine course at Stanford University, was the main speaker at a course on alternative medicine given across Canada in 1999 to members of the College of Family Physicians. While the course purported to arm physicians with enough

scientific knowledge to help them “speak with authority” about alternative medicine (letter of invitation to course, August 30, 1999), the main thrust of the two-day course appeared to be an attempt to prove that alternative forms of medicine were being sold to the public by the dishonest use of persuasive language. When one physician asked what could be done about patients who choose alternatives, she was reassured that there was little to worry about as family doctors had all the tools to treat their patients in a caring manner and that surveys proved that not many patients patronized alternative medicine (course question and answer period, October 23, 1999).

Dr. Sampson was possibly referring to a 1997 survey by Millar which found 15% of Canadians using alternative medicine. However Ramsay, Walker and Alexander in 1999, found 50% of Canadians using alternative medicine in the 12 months preceding the survey (Millar, 1997; Ramsay, Walker and Alexander, 1999; York University, 1999, 7). As noted before, one must be cautious in interpreting the extent of use as it will vary depending on what is defined as an alternative. Nonetheless, the aggregate of surveys conducted in Canada, the United States and Europe reveal the reason why physicians and governments are becoming concerned about regulation. As Julie Stone and Joan Matthews state, interest in regulation follows from increased use of complementary and alternative medicine. While people are not abandoning conventional treatments, one may perceive, though not prove, that more consumers are, in fact, consulting alternative practitioners or self-medicating on the advice of various popular magazine articles. Stone and Matthews add that representatives of some of the more established therapies, as well as the less well-established modalities within complementary medicine itself, see benefits in regulation. These representatives see increased consumer use as proof that the various modalities are a force to be reckoned with and ought not easily to be dismissed (see Stone and Matthews, 1996, 63- 64). The motivation behind the desire of governments to regulate, Stone and Matthews say, is

consumer protection, not economic motives or response to pressure from professional alternative medical groups (Stone and Matthews, 1996, 60).

Ultimately, the arguments for and against regulation come down to different perceptions about the extent to which the state should protect its citizens. A basic issue which Stone and Matthews say must be resolved is whether or not complementary and alternative medicine is “‘the same as’ orthodox medicine and therefore potentially subject to the same kind of regulatory control” (Stone and Matthews, 1996, 60). They argue that many of these therapies must be governed differently because their relationship with the government is different from that of conventional medicine.

In Canada, as in England, the state pays for basic medical care through taxes; alternative medicine is part of the private sector and does not use public funds. Unlike conventional medicine, it does not have a single spokesperson like the Canadian Medical Association or the British Medical Association. Many therapies lack the organization to be found in professions such as medicine, nursing or physiotherapy. In Canada, chiropractors and acupuncturists are well-organized. Chiropractic became regulated in ten provinces and in the Yukon and acupuncture in Alberta, British Columbia and Québec (York University, 1999, 133,140; Harden and Harden, 1997, xiv, 240). The government, Stone and Matthews argue, if it decides to create legislation, “will face an inherent tension between individual and collective rights, and must strike a balance between allowing individuals the right to exercise their own preferences in health care and the need to protect citizens from harm” (Stone and Matthews, 1996, 60).

Stone and Matthews are concerned that paternalistic attitudes inherent in conventional medicine will be adopted by governments attempting to control alternative medicine. The

British Medical Association appears to want statutory regulation only for harmful therapies. But should an individual be prevented from using an alternative therapy because it might harm, Stone and Matthews ask? They say that

one might reasonably question whether this is a legitimate area for statutory intervention at all, or whether it falls within the realms of private choice that responsible adults should be able to make. In respect of the practice of the more esoteric therapies, it could be argued that belief in its efficacy is more closely akin to religious or philosophical considerations and beyond the legitimate realm of statutory regulation (Stone and Matthews, 1996, 61).

They point also to the right of ethnic communities to choose their own healers without government interference. Freedom to choose a healing modality, they say, could be argued to be like freedom of religion. They point out that

not all rights have corresponding duties. Asserting that people have the right to believe in other forms of healing than the prevailing allopathic norm, does not necessarily mean that the Government has a corresponding duty to provide those forms of healing, although it might create a duty of non-interference. Where will the Government choose to draw the line once it begins to intervene in regulating unorthodox therapies? (Stone and Mathews, 1996, 61).

As Stone and Matthews point out, the British government has valued freedom of choice but the profession of medicine has an interest in controlling who is permitted to practice medicine in society. Stone and Matthews refer to these as political interests which “find expression most often in a criticism of the lack of scientific validation of complementary therapies and warnings of the potential such therapies have to cause harm to patients” (Stone and Matthews, 1996. 61).

These are issues faced by Canadians although the Canadian federal government has some limitations on its power to control the actual practice of medicine, either conventional or alternative, as this has devolved to the provinces. The next section will examine the various arguments for and against what Stone and Matthews suspect to be a paternalistic concern for the well-being of the public. Although paternalism has become a pejorative word, one

might cast it in the more positive light of beneficent concern. Many aspects of life are regulated. One purchases cosmetic products on the assumption that they will not harm. The assurance that a shampoo will not damage one's eyes, for example, is a result of government regulation. Similarly, one can place some confidence in a professionally licenced financial planner. If he or she behaves badly, she belongs to a group to whom one can appeal. It seems only reasonable to apply the same standards to alternative medical products, practitioners and practices.

Protecting the Public: the Stance of the Pro-and Anti-Alternative Medicine Groups

The growing popularity of alternative medicine has not gone unchallenged. Like members of certain religious groups, "true believers" on either side of the debate are quick to point out flaws in the group seen as the opposition. Just as some religious believers in early twenty-first century North America are intolerant of those with more nuanced and accommodating views, so too are the fierce defenders of either biomedicine or alternative medicine.

A number of groups have been formed either to argue for freedom of choice in medicine or to rebut the claims of alternative medicine. Many argue that the state has no right to interfere with the liberty of the individual to choose whatever form of healing he or she wishes. These groups equate the right to choose among a diversity of healing systems with freedom of religion (see Gevitz, 1988 , 21). The Vancouver-based Citizens For Choice in Healthcare is one such group (<http://get-info.Net/vn-cchc.htm>). Others include the Canadian Coalition for Health Freedom (<http://www.toronto.com/E/G/TORON/0020/00/80/csl.html>) and the People's Medical Society, founded by Robert Rodale, chairman of Rodale Press, publisher of many popular books on health (<http://www.peoplesmed.org/index.html>).

Other groups, some linked to the American Medical Association, argue that all alternative healthcare is fraudulent and that the state has an obligation to rein in its practice. Notable among those who believe the public needs protection from alternative medicine is the National Council Against Health Fraud (also known as The National Council for Reliable Health Information) and an associated group called Quackwatch which sponsors public information on alternative medicine. Its internet site analyzes particular types of alternative medicine, offers analyses of alternative medicine's metaphysical underpinnings and lists authors, books and journals which it considers to be dangerous or fraudulent. Popular authors with medical degrees such as Deepak Chopra, Herbert Benson and Larry Dossey are on their lists (Quackwatch home page, <http://www.quackwatch.com/index.html>; Barrett, <http://www.quackwatch.com/04ConsumerEducation/chopra.html>). Similar groups exist in England and have strong links to their U.S. counterparts. The major English group is HealthWatch, formerly The Campaign Against Health Fraud.

Groups which purport to protect the public from what they view as charlatanry claim that alternative medicine is metaphysical religion cloaked in medical language (see Raso, <http://www.ffrf.fttoday/march97/raso.html>). Some individuals are also genuinely alarmed at the acceptance of alternative medicine as an academic subject in faculties of medicine (see Schwartz, 1996, Nov, 28-32) and as a type of practice that can be covered by insurance. This, they believe, confers on alternative medicine a spurious legitimacy. The U.S. National Council Against Health Fraud (its website says "now doing business as The National Council for Reliable Health Information") objects to the protection of alternative practitioners through licencing laws and the weakening of laws which regulate the sale of alternative remedies (<http://www.ncahf.org>). Members of these groups appear genuinely concerned that the public will be harmed by alternative medicine. Aside from the obvious

concern that some will avoid needed treatment and others will waste money on that which cannot cure, critics, such as William T. Jarvis, the president of the National Council Against Health Fraud, profess themselves appalled at the lack of critical thinking which has led the American public to be “duped” by such alternative medical luminaries as Deepak Chopra who, from the Quackwatch point of view, mixes science, mythology and metaphysics with seeming abandon (see Barrett, <http://www.quackwatch.com/04ConsumerEducation/chopra.html>). William T. Jarvis and Stephen Barrett, MD, claim that proponents of alternative medicine (their term is ‘quacks’) use the concept of “ ‘health freedom’ ” to deflect attention from themselves and focus on the supposed victims of restrictive laws. These authors suggest that appealing to freedom of choice is a manipulative appeal to a value deeply embedded in American culture (Jarvis and Barrett, 1994, <http://www.quackwatch.com/01quackeryRelatedTopics/hfreedom.html>), a concern echoed by an American Medical Association document on alternative medicine (Sullivan-Fowler, 1989, 1). Jarvis and Barrett suggest that sick people “do not demand quack treatments because they want to exercise their ‘rights’, but because they have been deceived into thinking that they offer hope”(Jarvis and Barrett, 1994, <http://www.quackwatch.com/01/quackeryRelatedTopics/hfreedom.html>).

Many scientists are also alarmed at the rising interest in alternative medicine but take a nuanced approach. Rudy Baum, publishing in *Chemical and Engineering News*, says that “Science is being attacked from both outside and inside academe by radical environmentalists, practitioners of alternative medicine, fundamentalists, deconstructionists, feminists, sociologists, and philosophers.” He goes on to describe a three-day conference held in 1995 and sponsored by the New York Academy of Sciences. Called “The Flight from Science and Reason” its purpose, according to Baum, was polemic. Those gathered were believers in science and rational thought. However, Baum points out, “critics of

science are not universally irrational” (Baum, June 26 1995, 34). Thomas G. Donlan, another critic, sees official approval of alternative medicine as official malpractice and, in an editorial in *Barrons*, he caustically strikes out:

A nation that spends \$15 billion a year on alternative medicines and practices is a nation full of people who are frustrated by their childish desire for a cure as good as the other folks are getting. Alternatives have also won some support because they may be cheap. Thus, one sees cheapskate insurance companies pay chiropractors for massage techniques pass[ed] down from a ridiculous 19th century theory of illness rooted in the spine. Congress has also created an Office of Alternative Medicine at the National Institutes of Health, and charged it with serious investigation of claims dismissed by science. Tolerating practices that do not cause harm without rational evidence that they do good also amounts to tolerating quackery and fraud (Donlan, 1997, Mar 24).

On the other side of the debate, critics of biomedicine such as Martin J. Walker (*Dirty Medicine*, 1993) and the homeopath Harris Coulter, author of a four-volume academic work on the history of what he calls empiric versus rationalist medicine (see Coulter, vol.4, 1994), underline the political aspects of modern medicine. After the 1910 Flexner report (which was funded by the Carnegie Foundation) modern medicine benefited by its alliance with powerful charitable foundations and drug companies. Both authors view modern medicine as a system in which the doctor is a marketing and distribution tool for the pharmaceutical industry.

Coulter and Walker point to the extreme positions taken by the enemies of alternative medicine. Walker, while respecting the honest positions of early to middle nineteenth century members of such organizations as the Rationalist Press Association, which later joined the British Humanist Association, suggests that spin-off organizations, such as the Committee for Scientific Investigation of Claims of the Paranormal (CSICOP), in the U.S. and England, have degenerated from honest intellectual debate to poorly-researched attacks on proponents of alternative medicine (Walker, 1993,189-193). CSICOP is affiliated with the American National Council Against Health Fraud. CSICOP's main journal, *The*

Skeptical Inquirer, according to Walker, engages in propaganda (Walker, 59). CSICOP's main goal appears to be not only the protection of the public from what the organization deems to be fraudulent but protection from "thinking wrong thoughts" (Walker, 59).

Any technique that claims to heal illness has the potential to harm, hence the need for regulation. It should not be forgotten, however, that far more people are injured by conventional practices and practitioners. A speaker at the conference on *Complementary and Alternative Medicine in the Academic Medical Setting* (Philadelphia, November 10-12, 1999) pointed out that if as many jumbo jets crashed a day as the number of people who die in hospitals because of such incidents as adverse drug reactions, we would be alarmed. Concerns about the safety of complementary and alternative medicine should be put in this context.

Accommodation: Business and Government Attempts to Manage Alternative Products

The public is not served by extreme positions taken either for or against complementary and alternative medicine. Fortunately, probably due to an awareness of the increased use of alternative products and practices, private companies are attempting to regulate themselves and the federal government, which is responsible for products, is embarking on legislation.

Many consumers are not interested in the ideology of the skeptics, who debunk alternative medicine as junk science, nor in the enthusiasms of those who promote alternative medicine as healthier than biomedicine. They simply seek relief for a problem. Unfortunately, many consumers never consult a herbalist or naturopath. They simply self-medicate by purchasing products from pharmacies or health food stores. The drive towards standardization of herbal products is perhaps fuelled by this tendency. If unguided

consumers purchase a product then they should have some assurance that what they buy will do what it promises. To this end, Wampole Canada Inc. commissioned two studies, which they described as independent, of ten brands of St. John's Wort and twelve of Ginkgo Biloba, two popular herbal remedies. St. John's Wort is used for depression and, according to Wampole Canada Inc., can be used for anxiety, inflammation, as a sedative and in colds and arthritis. Ginkgo Biloba increases circulation to the brain and is an aid to memory and concentration. Each product was measured against an industry standard, which is set based on previous studies, and which determines the strength of the amount of active ingredient in the product necessary to render it efficacious. An independent laboratory in Montreal tested St. John's Wort for hypericin levels (hypericin is the active ingredient of St. John's Wort) and Ginkgo Biloba for flavonol glycosides.

0.3% Hypericin is the industry standard for St. John's Wort. Of the 10 products tested, only three passed the test. 24% Glycosides is the industry standard for Ginkgo Biloba. Of the 12, five brands did not achieve the 24% industry standard and three products revealed no active ingredient at all. To verify these results, Wampole then arranged for Forensic Accounting and Investigative Services in Denver, Colorado, to conduct an independent blind analysis. The second test validated the first and the results were sent to Health Canada (Wampole Canada Online Media Information, 1999, March 11, <http://www.wampole.ca/english/press/hqreport.htm>).

The products manufactured by Wampole were proven to contain the active ingredients, leading another major manufacturer of herbal products to accuse Wampole of a self-interested "public-relations stunt". The presidents of two other companies disputed the test results. One suggested that the company, which is new to the herbal products market, did not take into account the different results yielded by tests of raw materials versus

manufactured products (Abrahams, 1999, March 12, A3).

In spite of objections from competing manufacturers, Wampole's on-line press release quoted pharmacist Heather Boon as saying that the study was important because "Canadian consumers are buying these products assuming that the government, manufacturers and pharmacists have checked the quality of the products, but that is not always the case" (Wampole Canada Online Media Information, 1999, March 11, <http://www.wampole.ca/english/press/hqreport.htm>).

While one must always guard against the natural bias of a manufacturer promoting its own product through commissioned research studies, the study suggests that many of the products purchased from pharmacies and health food stores may be ineffective. This has been a concern of Health Canada since 1997 when it made its first moves towards regulating the natural products industry. The news of their interest was not, at first, welcome among herbalists, naturopaths and other alternative medicine clients and practitioners.

In 1997 groups of Canadian alternative practitioners and their clients launched a letter-writing campaign to protest Health Canada's decision to require purveyors of herbal and homeopathic remedies to be licenced and to object to the demand that herbal remedies be classified as drugs rather than food. Though the government's decision, ostensibly, had been made to protect the health of the public, alternative practitioners saw the hand of the powerful multi-national drug companies in this proposed legislation (see Lowey, 1998, May 14, E8). Though some of the polemical literature on the topic tends to demonize biomedicine by defining all opposition as a plot against those who merely want gentler and cheaper alternatives, another argument, favoured by some naturopaths and herbalists, is that herbal medicines should be evaluated under a separate category -- neither as a drug or a

food. In the end, this point of view triumphed and the proposed bill was withdrawn to be replaced by a panel (which included representatives of ethnic groups and alternative medicine practitioners) formed in May 1997 to advise on more effective legislation (Kennedy, 1998, February 3, A13).

Health Canada, in an interim report issued in February 1998 that led up to *Natural Health Products: A New Vision* (November, 1998), proposed that the drug regulatory system be changed to recognize that products sold as alternative remedies are “fundamentally different from drugs” and should therefore be controlled under a separate system which would be governed by those with expertise in this area. At present, many natural health products are regulated as foods, in which case they cannot make any medical claims. To make a medical claim requires an expensive drug license (Kennedy, February 3, 1998, A13).

The result of all this activity was the publication, in November, 1998, of *Natural health products: a new vision*, a report of the Standing Committee on Health, Health Canada. The report led to the creation of a separate Expert Advisory Committee to study the regulation of natural health products. It defined these products as made up of traditional medicines, such as Ayurvedic or aboriginal medicines, homeopathic preparations and vitamin and mineral supplements. It recommended that a new authority, responsible for regulating these products, be created. In March, 1999, the Minister of Health announced the creation of the Office of Natural Health Products. As recommended in the report, the new authority is responsible for assessing safety and efficacy (see Health Canada Information Backgrounder: <http://www.hc-sc.gc.ca/english/archives/releases/1999/9946ebk2.htm>)

The report states that evidence of efficacy should “not be limited to double blind clinical trials but also include other types of evidence such as generally accepted and traditional

references, professional consensus, other types of clinical trials and other clinical or scientific evidence (#21). It further suggests that different levels of evidence would be required depending on the type of condition the remedy is to be used for (#22) and that categories of natural health products be created to see “what level of regulation is appropriate for a particular product” (#25). It states that those who make, package, import or distribute natural health products, in Canada or outside, “be obliged to hold valid establishment licenses” (#17) and that regular inspections take place (#18). The report demands post-market monitoring with the request that adverse events be reported by the industry and through hotlines by practitioners and the public (#29). It also concerns itself with appropriate labelling (#32). Regulations, naturally, need to be enforced. The authors of the report state that rules should be applied regularly and consistently but, usefully, they suggest that this be done “in conjunction with education” (#48). They do not state if fines will be imposed or licences withdrawn (*Natural health products: a new vision*, list of recommendations November, 1998, handout at conference Complementary Medicine in the Mainstream, Toronto, Ont., November 23-24, 1998).

Natural products are probably the easiest forms of complementary and alternative medicine to regulate. More difficult is state regulation of practitioners and practices. The next section of this chapter will discuss the various philosophical arguments for and against state control of complementary and alternative medicine. Chapter ten will examine those aspects of public accountability that are the responsibility of professional associations which act according to the authority delegated to them by the state.

Important Elements in Public Accountability

Public accountability is made up of several mechanisms: state control; control by professional groups; licencing requirements; training programs; codes of ethics; sanctions;

complaint-handling procedures; information given to the public; equitable access.

Accountability increases if watchdog agencies -- either appointed by the state or the professional associations -- exist. State control will be the topic of this chapter. Control by professional groups, licencing requirements, training programs and codes of ethics will be discussed in chapter ten and sanctions, complaint handling procedures, public information and equitable access in the chapter focusing on justice, chapter eleven.

State Control

An important question many ask is the extent to which the state ought to be allowed to deprive people of the right to freely choose whatever medical or religious system they wish to follow.

Some control and legislation of alternative medicine is probably necessary if egregious harms are to be avoided. But too much government control of alternative medicine may drive unapproved practices underground, thus enhancing the appeal of unlicensed medicine and creating greater dangers. Part of the attraction of alternative medicine is its very alternativity. Those who choose it may believe it to be curative because it is not part of the dominant system. Alternative remedies may have a numinous quality. Fulder suggests that state regulations, or incorporation into the dominant medical system ("on the register" in Great Britain) may lead to alternatives to alternative medicine (Fulder, 1996, 5).

Arguments over protection of the public can be virulent, using the language of ethics and rights as a weapon and appealing either to freedom or to the need to protect the vulnerable (Caplan, 1980, 133). A number of ethical principles are appealed to in arguing for or against legislation: autonomy, beneficence and justice among them. Ethicist Arthur L. Caplan

discusses debates about the cancer remedy laetrile⁹⁸ as a paradigm for debates on liberty versus paternalism; political scientist Fred Frohock uses the fiduciary principle to argue for minimal legislation and anthropologist Arthur Kleinman, cautioning against over-legislating folk healers, uses arguments that could be extended to the wider arena of all forms of alternative medicine (Caplan, 1980; Frohock, 1992; Kleinman, 1984).

Caplan

Although laetrile is not as popular as it was 20 years ago, Caplan's analysis of the debates surrounding it are relevant to all discussions of the state's right to inhibit various forms of cure alternative to the dominant system.

Caplan says that questions of government authority and the "legitimacy of governmental sanctions" have been a concern of ethics for years (Caplan, 1980, 134). He saw as major ethical issues surrounding the laetrile controversy the right of government to control individual behavior and the correct role of government in regulating drugs and medicine for the common good (Caplan, 135). These arguments often appeal to the right to autonomy.

In the debates over Laetrile, those who supported it usually depicted its prospective consumers as autonomous. Critics saw them as needy victims who would believe anyone holding out the promise of cure (Caplan, 1980, 136). Caplan argues that the number of people who could be defined as vulnerable in this way is larger than we think. Those who may need protection are dependent on others and cannot easily protect themselves. They may be mentally competent but lack complete autonomy. Caplan says one could easily expand the category of what the medical research literature calls "vulnerable populations"

⁹⁸Laetrile was a banned anti-cancer product popular in the 1970's and '80's.

because “the insane, the seriously ill, the senile, some of the illiterate, some of the alien or newly emigrated, some of the handicapped, some of the drug-addicted, and, some of the institutionalized are all *prima facie* candidates.” Thus, he says, a very large proportion of society could be viewed as in need of protection (Caplan, 137).

Those who argued for serious restrictions on the sale of laetrile tended to paint the recently diagnosed cancer patient as so overcome by fear that he would be too emotionally overwrought to make truly autonomous decisions and thus would be open to manipulation. If such people chose laetrile then the anti-laetrile faction saw this as proof of some level of mental incompetence. However most people at some point in their lives suffer trauma of various sorts ⁹⁹ and yet no special legislation is enacted to protect the entire population. As Caplan points out, most people adapt to “transient vulnerability” (Caplan, 1980, 137-138).

In debates about alternative medicine, one has to ask not only who the weak actually are but what harm they are being shielded against. Caplan discusses two types of harm that could be created by the free sale of laetrile: “people may harm themselves or they may cause harm to others.” Self-harm could include a worsening of the disease through avoidance of conventional medical cures; the risk of serious side effects; the psychological harm resulting from the drug’s failure; the economic harm caused by the costliness of treatments. Harm to others could include forcing one’s own children to receive laetrile rather than conventional care; a reduction in funds for conventional cancer research as the number of prospective research subjects becomes smaller; becoming a financial burden on the state (Caplan, 1980, 139- 140); consigning spouses and children to penury because of the high cost of

⁹⁹In the twenty years since this was written, a diagnosis of cancer, though distressing, is not for many people as devastating as it once was as certain types of cancer now have very high remission rates.

treatment; depriving spouses and children of one's presence by choosing a therapy that might lead to an earlier death.

On the other side, however, morbidity and mortality is still too high for many types of cancers, cancer treatment is highly toxic and not always effective, the financial costs to government or, in the U.S., to individuals, are high and the physical and psychological burden on the individual and his family (especially if they are sent to another country for treatment, as is the case for Canadians sent to U.S. clinics because of the unavailability of equipment or specialists in Canada) can be as high as it would be with the use of an unproven therapy (Caplan, 1980, 140-141).

According to Caplan, the proponents of laetrile were aware of the pain that can be caused by making wrong choices but they saw this as the price of freedom from draconian legislation. Caplan saw the laetrile battle as representing the larger conflict in American life: personal freedom versus government power. Arguments for government power are centred on protection of the weak. Thus legislation governing medicine and drugs evolves "into a debate about freedom versus paternalism." Philosophy speaks of negative freedom -- the absence of external constraints -- and positive freedom which means that people have various options from which to choose. The regulation of laetrile, in Caplan's view, restricted negative freedom even though he believes some drug legislation is necessary. Caplan says that freedom of choice can be compatible with legislation which restricts. After all, in democratically elected governments, the legislators are mandated by the population to protect the population's interests. Paternalism is an issue when a person or state acts on behalf of another without authorization (Caplan, 1980, 142-143). It is considered acceptable to act on behalf of children or the mentally incompetent. To act on behalf of adults requires a mandate (in Québec, for example, individuals use a legal mandate to authorize others to act

for them if they become incompetent) at either the personal or civic level.

Caplan suggests that it is difficult to see how forbidding cancer patients to have access to laetrile increased their positive freedom proportionate to the restriction of negative freedom such an act entails. The moral case against legislation was, in his view, strong if this argument is used. Yet, Caplan says, other concerns are at stake. The first is that effective legislation must be universal. Those who criticized the laws against laetrile still favoured legislation to govern other drugs. They argued that laetrile was an exception because of the vulnerability and desperate needs of those with cancer. This is an awkward argument as many other remedies could be defined as “exceptions”. A law with many exceptions is difficult to apply and to observe. Another argument used was that legislation is also an attempt to curtail commercial fraud. Laetrile, as a commercial item, should be regulated. As Caplan says, either people with cancer “are competent or they are not.” If they are, then their disease is no reason to exempt them from legislation. If they are not, then they need government protection (Caplan, 1980, 144-146).

Caplan concludes by arguing that justice might require legislation so that a minority (the vulnerable) might be protected even though the majority would suffer limitations of positive freedom. While most people do not need protection, many do (Caplan, 1980, 147).

Frohock

Defining competence, however, is not easy. Perhaps the category “vulnerable” is more inclusive. While Arthur L. Caplan points out that the state seems to expand the notion of incompetence to include all those who suffer and who, therefore are vulnerable to persuasion (Caplan, 1980) Frohock appeals to the fiduciary principle to argue for minimal legislation. He discusses the ethical principles of beneficence and nonmaleficence as they

relate to alternative forms of medical care. While conventional medicine has increasingly emphasized informed consent as a way of ensuring no harm is done, in Frohock's view, the fiduciary principle is perhaps more important. This principle demands a trusting relationship between physician and patient and a responsibility towards the client/patient (Frohock, 1992, 275). Empirical science determines how the goals of medicine are accomplished; spiritual healing has other goals. These differences are important when examining ethical principles governing the practice of conventional and alternative healing, Frohock says. Healing in both fields is guided by the best interests of the patient but the interests of the patient of conventional medicine differ from those of the client of alternative healing (Frohock, 275-276). Alternative and conventional medicine have similar goals -- the well-being and healing of the patient. But alternative medicine operates on a system of beliefs -- scientific and spiritual -- which diverge, in some cases radically, from the system underlying the structures of conventional medicine.¹⁰⁰ Frohock says that "the deeper tests of ethics drawn from moral principles seem to be variables of competing senses of reality and the goals of different practices" (Frohock, 277). Much of his work attempts to negotiate between these two realities.

Needless to say, conflicts arise, not only between believers in alternative medicine and the state but among the different types of healing beliefs within the alternative community.

Schools of thought are not necessarily in agreement (Frohock, 1992, 228). But, as Frohock

¹⁰⁰ "All of the claims for unorthodox healing examined here rely in some way on beliefs in alternative realities. Both religious and psychic approaches to spiritual healing assume that the structure of the ordinary world, governed by those familiar assumptions of cause and effect, separate and distinct individuals, spatial arrangements of objects...does not exhaust reality. There is a reality, or realities, fixed somewhere outside of the domains of ordinary human experience and, the claims continue, contact with these alternative realities is the source for eliminating or curing illnesses.

"Unorthodox healing practices amend ordinary reality in various ways" (Frohock, 1992, 213)

says, "the most difficult conflict to adjudicate is the one that arises between the individual and the state. In liberal societies individuals are free to pursue idiosyncratic medicine so long as they do no harm to others and are legally competent. That is the guiding principle" (Frohock, 229). Frohock suggests that the conflict between conventional and alternative medicine is between differences in reasoning methods and disagreements about "principles and actions". It is difficult "because it concerns methods of reasoning and occurs at two conceptual levels" (Frohock, 234).

The State, Indigenous Healing, Traditional Chinese and Ayurvedic Medicine

Kleinman

Arthur Kleinman, in discussing legislation governing a specific group of folk healers, uses arguments that could be extended to many forms of alternative practice. He is cautious about legislation. He says:

Policy-wise, I am concerned that no policy be advanced for enumerating, registering, and controlling non-professional indigenous healers in the United States or elsewhere, until more research is conducted that can determine if such activities would be beneficial or counterproductive to the nation's health care. I tend to think it would be potentially dangerous (Kleinman, 1984, 158).

Kleinman feels that government control would attenuate the healing power of indigenous healing systems "...which seem to flourish in their present quasi-legal, unregulated status, and whose contribution is important precisely because it is non-professionalized and non-bureaucratized" (Kleinman, 1984, 158). His second point is that more research is needed to survey this type of folk healing before any kind of government intervention is made. He makes an important point: regulation can drive folk practitioners to the margins. If over-intrusive governments or professional societies attempt to catalogue and regulate all alternative types of healing, then many will operate underground, some in a fraudulent and

dangerous fashion. He fears allowing the conventional medical profession to dictate its definitions of health and appropriate health care which would bring alternative health care under biomedicine's control (Kleinman, 1959). His view, however, is nuanced. He feels that potentially toxic treatments or the potential for the abuse of power ought to be brought under some systematic control. He favors "...local research, followed by community-wide debates about what is to be done, in which regulating indigenous healing practices is a final, community, not professional, step" (Kleinman, 1959). Kleinman points to the dangers of commercializing indigenous healing (Kleinman 1980, 203-210; Ferguson 1981; Salmon and Berliner, 1980 in Kleinman, 1984, 159-160). Such healing systems may or may not be cost-effective but they are important to the spiritual and physical lives of individuals. They "... require a unique moral framework..." (Kleinman, 1984, 160).

In Canada, traditional natural healing is viewed as a category separate from alternative medicine (unless practiced by or resorted to by non-natives). It is largely practiced by native Canadian healers and sought after by members of aboriginal communities. It is a type of healing associated with respect for traditional native values and practices and is unregulated, with no school or accreditation program. In general, no text-books of native healing exist as healers fear exploitation of their practices. Healers are recognized as such by their own communities. Traditional native healing is practiced in hospitals found on native reserves such as that at Kahnawake, Québec and at Anishnabe Health, Toronto. Incorporating native healers in the hospital system has raised some significant issues. Can a healer receive hospital privileges (the right to practice in the hospital) in the same way as physicians? Can healing be effective in a hospital? Can patients be kept medication-free so as to participate effectively in healing ceremonies? How can healers receive adequate reimbursement if their tradition is to accept only a gift? Who determines liability for failed treatment (York University, 1999, 290-293)? Some of these issues are similar to those faced by all types of

alternative healers invited into the hospital setting.

Representatives of communities that practice their own form of medicine made presentations to the Canadian government's Standing Committee on Health Regarding Natural Health Products (see Health Canada Report of the Standing Committee on Health, <http://www.parl.gc.ca/InfoComDoc/36/1HEAL/Studies/Reports/healrpO2-e.htm>). Chinese Canadians argued for tolerance. Joseph Wen-Teng Wu, a representative of the Committee for Preserving the Integrity of Traditional Chinese Medicine, argued that Chinese medicine is a unique system rooted in a cultural and historical world different from Western society. He spoke of the different paradigm in which Chinese medicine is grounded and said

I say that it is improper, for the government that calls itself multicultural and tolerant, to uphold the world view of the West as superior to the world view of the East, especially where it concerns the unique system of herbal medicines that were developed to maintain the well-being of an entire people and that plays such an integral role in the culture (Joseph Wen-Teng Wu, brief presented to the Standing Committee on Health, August 20, 1997 cited in York University, 1999, 299).

The Chinese Canadian National Council echoed Mr. Wen-Teng Wu's concerns, that "any health system is ultimately accountable to the people it serves." The representative of this organization, J. Ma, pointed to the increasing diversity of the population of Canada and argued that "the system cannot remain monolithic, but must provide consumers the freedom to choose among alternatives" (Ma, transcripts of presentations to the Standing Committee on Health, March 17, 1998 cited in York University, 1999, 299). The director of the Toronto School of Traditional Chinese Medicine, Mary X. Wu, argued that Traditional Chinese Medicine, a 5,000- years -old part of "Chinese culture and philosophy" is so different a medical system that any regulations protecting safety and determining efficacy and side effects should be evaluated using different standards from those used to measure Western alternatives. To use Western knowledge of pharmaceuticals to assess Chinese herbal products, she said, would be ineffective as "they don't understand the Traditional

Chinese medical theory or the theory of Chinese herbal medicines” (Mary X.Wu, from the transcripts of the Standing Health Committee, February 4, 1998, cited in York University, 1999, 300).

The national director of Maharish Ayur-Ved College felt the same about supervision of Ayurvedic medicine and ayurvedic products which are part of a long-standing tradition in India (Dr. Richard Wolfson, from the transcripts of presentations to the Standing Committee on Health, February 17, 1998, cited in York University, 1999, 300).

The State and Legislation for Complementary and Alternative Medicine in the Hospital Setting

The current interest of some practitioners of conventional medicine in incorporating some forms of alternative practice into the conventional setting is one way to mediate the conflict between alternative and conventional medicine. This method is not without its problems even if a hospital does not use aboriginal, Chinese or Ayurvedic medicine. Much of the attraction of some Western types of alternative medicine is its spiritual component. Biomedical science, with its mechanistic view of nature and its strong need to examine, analyze and explain, might rob certain types of alternative medicine of their power. Just as some patients of conventional physicians do not want to know what is to be done to them because they need to believe in the mystique of the medical art, so too do practitioners of alternative medicine need to be allowed to approach the sanctuary of healing reverently. However, they may find their values compromised by the demands of hospital practice. That which is sacred is often veiled and concealed from human view. Exposing alternative medical practice to the probe and the bright lights of biomedicine might be an unfortunate mistake. Casey House Hospice in Toronto, in its policy on Complementary Therapies, insists that alternative therapists document their interventions in the medical chart (Casey House

Hospice, Policy # 5.488; 01/04/98 in York University, 1999, 371). While on the surface a reasonable requirement (a medical chart exists so that all involved in a patient's care are aware of the interventions and diagnoses of others), wisdom might dictate that some types of client-therapist communication be kept out of the chart. A similar difficulty exists for professionally trained chaplains as the governing body encourages practitioners to document interactions in the medical chart. Ought the deepest fears and spiritual explorations of patients be exposed to all the medical and ancillary staff? Medical charts are reductionistic and it is too easy to impose biomedical labels on expressions of inner turmoil.

Other difficulties arise when biomedicine attempts to co-opt other systems because alternative medicine, as Frohock emphasizes, operates on beliefs about illness, its etiology and cure, which differ from the beliefs of conventional medical science. Berliner points to medical enthusiasm about acupuncture in the early 1970's. Conventional neurological medicine had no place for the concept of acupuncture meridians as the channel for the reduction of pain even though many physicians were sufficiently interested in this ancient art to travel to China to observe and study acupuncture (see Berliner, 1984, 52).

Biomedicine might raid alternative practices for that which is useful while ignoring its broader, holistic and spiritual claims. It thus runs the danger of entirely missing the point. Alternative practitioners who strive to become respectable and legally authorized might feel obliged to imitate the worst (from the patient's point of view) practices of conventional medicine (see Fulder, 1996, 92). Patients in a training centre for alternative medicine might, for example object to being seen by a different student on each visit to a hospital-like alternative health clinic. Kleinman, referring to official medical centres that include indigenous healing methods says that while some (he cites M.Taussig) may see biomedical interest as a conspiracy on the part of "professional biomedical institutions to engulf and

incorporate threatening and competitive indigenous components of the other therapeutic sectors", he rejects this point of view (Taussig 1980 in Kleinman, 1984, 161). The same might be said of alternative healing.

Proponents of complementary and alternative medicine point to the very serious harm which biomedicine can inflict. Alternative practitioners often describe their form of medicine as "natural", safer, gentler. While they consider themselves to offer a benign, and therefore more ethical form of medicine (less intrusive, invasive or aggressive), all forms of healing have the power to damage -- spiritually, psychologically, physically, socially or economically. Alternative medicine should be no more immune than religion from ethical analysis (see Battin, 1990). This thesis argues for limited legislation so that the public may use alternative medicine safely. Although Health Canada has taken control of herbal products, extensive legislation in all provinces, designed to control all aspects of complementary and alternative medicine, will probably be enacted only when representatives of conventional medicine recognize some of the claims of alternative medicine. Representatives of conventional medicine, when they support laws to curtail the practice of alternative medicine, maintain their own dominant position. To reverse this position and support laws regulating the safe practice of alternative medicine appears to give tacit approval -- a position many conventional doctors reject.

Proposals for Types of Legislation

Much of the legislation governing alternative medicine in Western nations was, in the view of critics, created to protect the power of allopathy. In the U.S. and Canada, non-physicians can be charged with practicing medicine without a licence. In the U.K., physicians have never been licenced, but registered. The next chapter will look in more detail at the way health care is regulated by professional groups in Canada. However, it is important to note

that Canadian law regulates medical acts in different ways: among them, through the civil code, in Québec, which delineates the rights and obligations of patients, health care institutions and boards; through the criminal code; through the professional codes by which health care professionals govern themselves under the mandate of the provincial governments. The federal government is responsible for the Canada Health Act which ensures that Canadians have access, free of charge, to many types of medical care. Through the Public Health Act, the federal government prevents individuals from refusing treatment for tuberculosis or syphilis. Through the Health Protection Branch of Health Canada, it ensures that products and devices such as breast implants are safe. Through the Canadian Institutes for Health Research (formerly known as the Medical Research Council) it ensures that research on drugs is conducted equitably, ethically and safely. Even if these institutions fail to protect (Canadians in many cities have reduced access to radiotherapy; the Health Protection Branch has been attacked for failing to prevent the use of silicone breast implants), the public can demand that they explain themselves to those they serve.

Faced with the growing popularity of alternative medicine, governments have at least four options: they may analyze, evaluate and legislate for the various types of alternative medicine, even setting up and accrediting schools of alternative medicine; they may ban certain types outright; they may take a laissez-faire approach and allow all forms of alternative medicine to function on the fringe. Their fourth option is to help professional associations organize their own training standards, training programs and registers and officially recognize these groups. This is Martel's proposal (Martel, 1992) and it has merit both for its flexibility and practicality. It would allow for minimum government legislation while protecting the public with state recognized (not authored) laws or guidelines. Guidelines and minimum legislation are necessary but freedom of choice must be protected. One may set up ethical guidelines for the practice of alternative medicine but the clients

should then be free to make their own choices without heavy-handed interference from government or professional bodies.

Conclusion

Canada was founded on the principles of Peace, Order and good Government (*Constitution Act*, 1867, (U.K.), ss91). These sober values, rather than the right to the pursuit of happiness, are embedded in the Canadian Constitution and probably buried deep in the Canadian psyche. Where the American might appeal to the right to use alternative medicine as part of the right to life, liberty and the pursuit of happiness (although Canadians, like Americans, have rights to life, liberty and security of the person), Canadians, in general, might approve of laws which would limit these rights for the greater good. Much of Canadian life is legislated. When a new technology makes its appearance, Canadians, in general, are quick to form commissions of inquiry and bodies to draft guidelines and legislation. Canadians appear reluctant to allow medicine and science the freedom of the marketplace. As well as legislation, education is necessary. The report from York University recommended that Health Canada undertake public education and create various educational programs to foster dialogue among and between conventional and alternative practitioners (York University, 1999, xvii, 307).

Chapter Ten

Non-Maleficence and Beneficence - Professional and Local Accountability in Complementary and Alternative Medicine

Introduction

A difficulty in regulating the field of complementary and alternative medicine is the diversity of its practitioners as well as its methods. It includes nurses, pharmacists, veterinarians (who practice complementary and alternative medicine on animals) and medical doctors who practice homeopathy alongside self-taught eclectics who may combine herbal healing with astrology and crystal channeling. In some cases, the naturopath or homeopath may be better trained in the specialty than the physician who has taken a short course. A medical degree does not automatically confer the ability to practice an alternative form of medicine.

Many believe that those who offer healing should belong to a state-regulated professional association to which they are accountable. Part of informed consent should include information on where to go for recourse if the client is dissatisfied. For this reason, the client would be well advised to find out whether the practitioner is a member of a professional association. Many associations of naturopaths, homeopaths, massage therapists and others have developed codes of ethics and have well organized disciplinary procedures for practitioners who break the code. A client might ask whether a code of ethics is available. This would bring the alternative professions into line with the standards of Québec hospitals¹⁰¹ and organizations of health care professionals.

¹⁰¹Québec government Bill 120 requires all hospitals and health care establishments to tell patients how to lodge a complaint and to make available a code of ethics spelling out rights and obligations.

The last chapter examined the need for government regulation of complementary and alternative medicine and analyzed the various philosophical arguments for and against regulation. This chapter will focus on those aspects of accountability that are controlled by the professional associations to whom governments delegate, by legislation, the power to control the acts and behaviour of their members. It will look at licencing, registration and certification; education and training and codes of ethics. Sanctions, complaint systems, and public information will be the topic of chapter eleven. To place these issues in context, a knowledge of Canadian health legislation is useful.

Licencing, Registration and Certification

Canadian Regulations

In Canada, the provinces and territories have been given the power to govern health care. In most places, health care providers are licenced or certified although some types of providers are unregulated.

A licence means that only those who hold it can practice those therapies that fall under their scope of practice. This scope is determined by legislation. Other health care providers may be permitted to perform, for example, medical acts which fall under the scope of practice of the medical profession (for example, nurse practitioners conducting pelvic examinations on women) but the right to so act is delegated to them by the medical profession. Some are authorized to perform an act within the scope of practice of a profession by a separate statute. It is an offence to practice those acts without a licence or other authorization (York University, 1999, 92-93).

Certification means that only a qualified practitioner is permitted to use a title. This “reserved title” indicates that the practitioner has met educational requirements and is governed by a code of ethics. It does not mean that only a certified person may practice, for example, psychotherapy. For example, in Newfoundland, *The Psychologists Act* does not permit unregistered persons to call themselves psychologists. However, an unregistered person may practice forms of psychology, such as counselling, as long as she or he does not use the title (Morris, 1996, 48). However the reserved title (social worker is one such title) is an assurance to the public that the individual is accountable (York University, 1999, 93).¹⁰²

Provinces can have professionals who are governed by licence and others who are certified. Physicians or pharmacists have a licence to practice and the right to an “exclusive scope of practice”. Physiotherapists or psychotherapists may have only the right to the title.

Naturopaths might be regulated by statute in some provinces and not in others, where they would be governed by general laws (York University, 1999, 93), consumer protection laws or the criminal code for example. The following is a detailed presentation of the regulation of alternative medicine in Canada. Québec province has been given a separate section because of Québec’s different legal system. This exposition will be followed by a summary of the situation in Britain, as a point of comparison.

As noted in the last chapter, legislation has been enacted in all Canadian provinces and territories to establish systems to ensure that each profession regulates itself, setting professional standards, criteria for entry to practice, taking responsibility for licencing or registration of members, continuing education, and discipline. Some provinces incorporate

¹⁰²J. J. Morris, author of *Law for Canadian Health Care Administrators*, says that governments are now inclined towards restricting not only the right to use a title but to restrict the scope of practice. This has usually been the case with conventional medicine; non-physicians are prohibited from practicing medicine (Morris, 1996, 48).

all professions under a type of umbrella legislation; others, such as Manitoba, have special statutes governing nursing, physiotherapy and some types of alternative medicine such as naturopathy. British Columbia's umbrella legislation, the *Health Professions Act*, creates a Health Professions Council which decides whether a health profession should be designated under the act and thus bound by its provisions, which include the requirement that the profession create a "College" which is responsible for its members in the same way as the provincial colleges of physicians (Morris, 1996, 44-45).

In some areas, a regulated health profession may still be practiced by those not governed by a provincial association although they may not use the reserved title. Restrictions on the right to practice medicine are at the heart of difficulties between some alternative practitioners, like homeopaths, and official medical regulatory agencies. Ontario regulates health professionals and sets boundaries on the scope of practice under the *Regulated Health Professions Act, 1991*. It has recognized 21 health professions, an increase over the five governed under the earlier *Health Disciplines Act*. The act defines treatments considered "controlled" which includes giving a person a medical diagnosis and performing specific types of invasive procedures (Morris, 1996, 49). An alternative practitioner is not permitted to give a medical diagnosis, as noted above, although a physician may delegate an act to a health professional under specific regulations found in the act.

Québec

Québec has a legal structure which could evolve to accommodate alternative medicine and its practitioners. Two provincial laws, the *Code des professions* (L.R.Q., c.C-26) and the *Loi médicale* (L.R.Q., c.M-9) are applicable. Twenty-four professional corporations govern or are related to various types of health care. These corporations control either the reserved

titles or the exclusive right to practice. Medical doctors have both a reserved title and an exclusive right to practice. Only two alternative professions are part of a professional corporation, and they have the exclusive right to practice -- chiropractors and acupuncturists (York University, 1999, 94; Code des professions, L.R.Q., c-C-26, 2000, #32). Paul Martel, a lawyer who specializes in alternative medicine, proposes a parallel system for alternative medicine which would regulate complementary and alternative practitioners but free them from the demands of the *Office des professions* (Martel, 1992, 167). Martel is the founding member of a number of associations of alternative therapies. His book, *Attention Santé*, is a comprehensive analysis of the role played in public health by alternative and conventional systems of medicine. He makes many proposals for the regulation of the field of alternative medicine which are of value to anyone attempting to create regulatory guidelines.

The Rochon Report (the report of the *Commission d'enquête sur les services de santé et les services sociaux* which began in 1988) had recommended that the *Office des professions* create a new system to control those practitioners whose activities represented a risk to the public. This recommendation is to be found in the April 1989 document *Pour améliorer la santé et le bien-être au Québec* (Martel, 1992, 160).

The *Office des professions* conducted a large-scale study of alternative medicine and, in April 1992, made recommendations to a parliamentary commission on alternative therapies that no government regulations, beyond a few amendments to the *loi sur la protection du consommateur*, were needed (Martel, 1992, 201-202). The office did not want to create a professional corporation. An organization set up to propose legislation for alternative medicine objected to the *Office des professions*' conclusion saying that anyone who claims to treat people can potentially harm them because of the close and confidential relationship that can exist between practitioner and client. The laws of the marketplace, this group say,

are not sufficient (Martel, 307).

In 1992 (not 1993 as stated in the York University report), the *Office des professions du Québec* (Office of Natural Health Products Professions) presented a report in which it proposed that, among alternative practitioners, only homeopaths and acupuncturists be regulated by the *Code des professions*. It did not want to extend the Code to massage, naturopathy or herbalism, for example. The authors recommended that “registered homeopath” and “registered osteopath” be reserved titles and that only those who were already members of a professional corporation (for example, physicians, veterinarians and pharmacists), and who demonstrated competence in homeopathy or osteopathy, be allowed to use the reserved title “homéopathe agréé” (York University, 1999, 94, citing *Avis au ministère responsable de l'application des lois professionnelle sur l'opportunité de constituer une corporation professionnelle dans le domaine des médecines douces*, 1992, 19-20). This, effectively, restricts the practice of homeopathy to doctors, nurses and other health care professionals. However, the authors of the report did not recommend that sales of homeopathic, naturopathic or phytotherapy (herbal) products be restricted. They wanted to modify the consumer protection law so that it could be applied to alternative practitioners without demanding that they become members of a corporation. Finally, the report recommended that the public and insurance companies recognize only those alternative practitioners who were not connected to educational institutions (perhaps this refers to those practitioners who do not own and administer private, unaccredited, training schools), had completed a minimum level of education in their field and who could produce a code of ethics for the public (*Office des professions*, avril 1992, 19-20; York University Centre for Health Studies, 1999, 94-95).

As we will see from the discussion below, these minimal requirements do not go very far in

protecting the public. While the requirement of a minimal level of education is important and should include at least university-level science, the report does not, in its recommendations, specify what a minimum level of education would be for many types of alternative medicine. While chiropractic is controlled, naturopathy is not. Furthermore, codes of ethics may be nothing more than window dressing. Unless breaches of the codes of ethics have teeth, they may give the illusion of ethical awareness but are no guarantee of moral probity.

Alternative medicine in Québec is governed by the laws of the marketplace (Martel, 1992, 73-75). At the moment, in Québec, alternative practitioners are accountable to their own private organizations. Unhappy consumers can appeal to the *Loi sur la protection du consommateur* or the regular courts. This, in effect, distinguishes alternative from conventional medicine. Conventional medicine is not seen as a consumer product but as an essential service; alternative medicine is reduced to a purchased commodity, and its practitioners have no more status than hair stylists (see Martel, 62).

Martel points to the dangers posed to the public and the state by lack of recognition and regulation. He describes four problems: the absence of consistent training standards for practitioners who are not required to submit themselves to any standards or control; the lack of information given to the public on the nature of therapies offered, “their effects, their limits and the qualifications of their practitioners;” the “fact that alternative therapies operate in the black economy which deprives the state of revenue” (he seems to assume that many alternative practitioners do not declare their income); the difficulty in obtaining funds to conduct adequate research into alternative therapies and their effects (Martel, 1992, 73, Trans. O’Rourke).

Like the *Office des professions* itself, Martel is not confident that the *Office des professions* is the appropriate structure to regulate alternative therapies. Its control might be justified when the care given is risky; it would be absurd to apply its regulations to such innocuous therapies as aromatherapy (Martel, 1992, 160). However, the *Loi sur la protection du consommateur* is probably inadequate to the task.

Martel believes that the public would best be protected by an organization which covers all (his emphasis) alternative therapies, those which pose a risk to the physical and mental health of the population and those which do not. He draws attention to the fact that risk includes financial hardship as well as the “exploitation of the gullible and ill-informed.” “In this sense,” he says, “each alternative therapy, no matter how inoffensive medically, represents some risk to the public” (Martel, 1992, 161, Trans. O’Rourke). He suggests that mechanisms inspired by the *Loi sur la protection du consommateur* or the *Loi sur les valeurs mobilières* would more effectively protect the public against fraud than the laws governing the professions. He adds that one must also impose “minimal and practical rules of ethics” and says it is important to determine which alternative therapies present a real risk to the health and well being of the public. Practitioners of these therapies must comply with “minimal standards of training and competence” and adhere to strict regulations. Rules, he says, must be “flexible”; “cover all therapies and disciplines” and “permit access to all information required on the therapies and the therapists” (Martel, 161, Trans. O’Rourke).

Martel describes a group of therapists and consumers who gathered to discuss recognition and regulation of alternative therapies in Québec. They proposed a structure which would allow for:

1. the registration and giving of permits for all therapies
2. respect for minimal norms of practice and ethics for all therapies
3. a mechanism of certification or official recognition of certain therapies
4. the dissemination of complete information on the therapies and therapists for the public
5. sanctions against therapists who contravene the regulations
6. the creation of an organization or office charged with applying [the regulations] and the structure (Martel, 1992, 162-163, Trans. O'Rourke).

This proposed structure was a modified version of a 1982 Californian model from the Board of Medical Quality Assurance of the Department of Consumer Affairs of California.

Martel says that "the major advantage of this structure is that the state would not have to immediately recognize those alternative therapies which it cannot politically defend, but it would be able to *regulate* all therapies through registration and the imposition of rules of conduct. Furthermore, the organization would not have to go through a lengthy evaluation process for each therapy" (Martel, 1992, 163, Trans. O'Rourke).

Martel proposes two systems of licencing: registration followed by the granting of a permit and certification, which would be necessary for riskier therapies.

Québec -- registration and permits

All people who want to practice as alternative therapists would first be obliged to register before obtaining a permit. "Registration would require payment and the complete disclosure of the following information: the name of the therapist and his/her home and office address and phone number; the name and description of the disciplines practiced; a description of the way in which employees are managed; a list of courses taken and a description of the training received, with diplomas attached; a description of the experience acquired with proof; a list of the fees charged; the names of the associations of which the therapist is a member. This information would be contained in a file on each therapist along

with other relevant information. The permit would be renewable annually with information updated as required. A registry of alternative therapists with information about them would be accessible to the public.” Permits would only guarantee the validity of the therapist’s practice (Martel, 1992, 163-164, Trans. O’Rourke); they would neither endorse nor guarantee competence.

Each registered therapist would be obliged to give to each of his or her patients the following notice (an adaptation of a Californian model). It reads:

The province of Québec does not evaluate the formation, experience or competence of the therapists registered. Registration does not constitute an endorsement nor a guarantee of the competence of the therapist. The province of Québec cannot verify nor certify the knowledge of any of the registered therapists, nor attest to the efficacy of the techniques used. The consumer must make his or her own judgement to determine if the therapist is able to furnish the required services.

The registered therapists are not able to make a medical diagnosis. Only a physician and certain other therapists may do this. If you have any questions about your state of health, you are invited to consult a physician or another therapist (Martel, 1992, 165, Trans. O’Rourke).

“The system of registration would be extended not only to alternative therapists but also to health care professionals who wish to use alternative therapies in their practice. In this way, the public would have a complete picture of alternative therapies and therapists. Health care professionals would still have to comply with the laws and regulations of their own disciplines” (Martel, 1992, 165, Trans. O’Rourke). Nurses, for example, would still be obliged to follow the norms of their profession.

Québec -- certification or recognition

Certification might follow registration. “Certified therapists whose practice represents a risk to the public but who do not wish or are unable to obtain membership in a professional corporation according to the statutes of the *Code des professions*, would find in the proposed structure a mechanism of certification or recognition.” “To obtain certification,

the therapist must meet the minimal standards of training and be a member ('en règle') of a recognized association of therapists in the discipline. For an association to be recognized, it must satisfy minimal organizational norms, which would include control of training, a permanently established training program, and a mechanism for disciplinary control. It would be possible to have more than one association recognized in a particular discipline [homeopaths, for example are trained in different ways and belong to different associations] the moment each one satisfied the demands made for recognition" (Martel, 1992, 167, Trans. O'Rourke)

Therapists described as "certified" would receive official recognition, comparable to that of professionals governed by the *Code des professions*. They would enjoy all the advantages but would not have to submit themselves to the onerous demands of the *Code des professions* (Martel, 1992, 167). "Recognized associations would play a role similar to that played by professional corporations, and would be responsible for admitting members and providing permanent training" (Martel, 1992, 167, Trans. O'Rourke).

Risky alternative practices would need to be certified but, Martel says, the members could have a reserved title. Therapists practicing low- or no-risk therapies would not be obliged to become certified but it could be to their advantage. The general public, if it knew who was and who was not certified, might prefer to consult certified therapists. This would obviously be an advantage to certified therapists who might attract and keep more clients (Martel, 168). Martel anticipates that many therapists would want to obtain certification because many, such as naturopaths, massage therapists or homeopaths already belong to their own professional associations (Martel, 1992, 168).

Martel discusses the special case of "*guérisseurs*" (folk healers) who do not, according to

him, need certification. He believes that their registration with the proposed organization would be sufficient. If some think it necessary to raise standards in this field, he suggests using standards of efficacy, not training standards, in accordance with the French and British models. He makes exceptions for those healers who might be asked to work in health care institutions alongside official physicians (Martel, 1992, 170). This is an issue for native healers practicing in hospitals on reserves, as noted in the previous chapter.

Martel believes that the the proposed certification system has several advantages. It “offers alternative therapists a viable solution to the inadequate system of the professional corporations”; can be organized from the already existing associations of alternative therapists; it avoids the tensions that result from mergers; it encourages collaboration among the many therapies and avoids the danger of groups jealously clinging to titles or acts reserved to them alone. Collaboration would be enhanced by the code of ethics and by the fact that therapists representing various disciplines would have decision-making power on “boards of recognized associations.” Other advantages of the system would be protection of the public because all information on therapists’ training, experience and fee structure, whether they were certified or not, would be available to the public. Doctors and other health care professionals could also become certified to practice complementary and alternative medicine (Martel, 170-171, partial Trans. O’Rourke). This last point is contentious within Québec’s medical community. The Québec College of Physicians views homeopathy as a therapy of no value. Nonetheless, it believes that only physicians should practice homeopathy though it says they behave improperly if they offer homeopathic treatments in place of conventional treatments (York University, 1999, 227).

Martel’s proposal has great merit in that it avoids the problems posed by the weak controls of the *Loi sur la protection du consommateur*, which reacts to complaints from the public

rather than creating regulations. However, although Martel says that his method of registration and certification avoids the complexities attendant upon joining a professional corporation, the professional body he proposes to govern alternative medicine could become a parallel, and equally complex, structure.

Great Britain

In Britain, certain paramedical health care workers are registered with the government as Professions Supplementary to Medicine as recommended by the Department of Health. This is easier to obtain than full registration. However, these groups always work under physicians who make the initial diagnosis (Fulder, 1996, 75-76). Stephen Fulder states that therapies which are most similar to medicine, like acupuncture, are divided on the question of full registration. Alternative practitioners have considered the advantages of this type of official registration. Some feel that registration, as well as making it possible for alternative practitioners to function within the National Health Service, might also inspire public confidence and ensure high standards (Fulder, 1996, 71-73). Others see disadvantages which include control over training exercised by medical doctors, a “medicalization” of the alternative philosophy, and loss of consumer choice. Registered practitioners might focus more on the treatment of illness than the maintenance of health because of the “sickness-orientation” of modern medicine. Other problems include more bureaucracy and the expense of managing the committees required by registration; reduction of the therapist’s role to one specific treatment (chiropractors restricted to treating only bad backs; herbalists allowed to administer only those remedies proved efficacious and safe in clinical trials), and yielding the right to diagnose to the doctors who refer patients to alternative therapists (Fulder, 73).

In England, alternative medicine has been incorporated into the practices of some general

practitioners (Liverpool Centre for Health) as described in chapter four. Problems encountered in this arrangement included doctors who did not give alternative therapists sufficient referral information; “dumping” of patients with chronic illnesses on the alternative therapists; a demand for results more rapid than is possible in alternative medicine; lack of a “holistic” ambience for therapist and client (Fulder, 1996, 91-92). In contrast, the GP’s were happy to find a way to reduce their patients’ use of drug therapies and avoid sending them to hospital outpatient departments. The patients were also reported to be content. They were said to have learned to speak two “languages”, informing their alternative practitioners of changes in quality of life and telling their GP’s about quantitative changes that they supposedly invented so as to ensure they could continue in treatment (Moore, 1995 in Fulder, 92-93).

In Britain, the House of Lords debated registration for osteopaths in 1985. The government did not want to offer more power to alternative medicine, nor did it wish to create more regulations. The government took a stance of “benign neutrality”. However, as alternative medicine became more popular, the Department of health became less welcoming and demanded that, before registering themselves

...the practitioners themselves would have to demonstrate, by objective scientific evidence, firstly that their system of therapy was valuable, and secondly that registration was necessary for the protection of the public against persons not qualified to practice it (Trumpington, The Baroness, 1987, cited in Fulder, 1996, 74).

In 1991 a working party (created in 1989 by the King’s Fund) recommended that osteopaths became eligible to join the register after some postgraduate training, and appended a Draft Bill to the report. The Bill (a Private Members Bill) became law in 1993. This was important (“an historic event” Fulder says) as “the first full acceptance of a complementary therapy, implying the end of centuries of medical opposition.” The

profession was to be organized with four statutory committees taking care of education, investigations, professional behavior and health. It would be controlled by a new General Osteopathic Council answerable to the Privy Council. This council is like the General Medical Council. It governs standards, looks after the register and disciplines unprofessional conduct. Those who pass accredited courses are then eligible to be listed on the register (Fulder, 1996, 74- 75). Chiropractic went through a similar process and *The Chiropractic Act* was passed in 1994.

Although a 1986 British Medical Association report¹⁰³ accepted alternative medicine only under the paternalistic supervision of conventional medicine, the 1993 British Medical Association Report benefited from the opinions of practitioners of alternative medicine. It looked at alternative medicine from the perspective of public health and consumer choice. The report recommended that each alternative therapy create an organization so that it could be regulated, have enforceable codes of conduct and educational standards (Fulder, 1996, 18-19). It did not concentrate on scientific verification (Fulder, 53).

All the groups who became registered appeared to have several things in common: the profession had become unified; the level of education improved; training courses offered more biomedical content and the scope of treatment was limited to specific areas of the

¹⁰³The Corporation (now College) of Physicians of Québec *Task Force on Alternative Medicine* used the BMA 1986 report as a framework for discussion (1989, 10). The Corporation seemed to take a reductionist view, seeing the value of alternative medicine in its placebo effects (8-9). The placebo effect has often been dismissed in conventional medicine because conventional medicine places more emphasis on the action of the treatment on the patient, not the patient's own role in becoming ill or regaining health. The report suggested that physicians need only listen effectively and spend more time with patients so as to enhance trust. This, they believed, would act as a placebo and encourage patients to become well (1989, 29). The suggestion flies in the face of reality. Not only is medical practice built around the concept of the very quick doctor-patient visit, in the cash-strapped Québec system, even salaried doctors have too many patients to devote time to each one.

body. Fulder notes that registration has already increased medical referrals (Fulder, 1996, 75).¹⁰⁴

Other forms of alternative medicine are accepted officially. Homeopathy, which many describe as a complete medical system¹⁰⁵ has been part of the National Health Service since its inception. The British Minister of Health in 1949 gave homeopathy an “ ‘absolute guarantee’ ” that it would continue as long as it was demanded. However many homeopathic clinics and hospitals have since closed (Fulder, 1996, 78-79). Hypnosis, like homeopathy, was introduced in the last century by “heterodox” medical doctors. Both, according to Fuller, have therefore been more vulnerable to suppression from within the ranks of physicians than from external legislation (Fulder, 80). Hypnosis is, however, accepted by the Psychological Medicine Committee of the British Medical Association.

In England, herbal medicine has faced battles similar to those in Canada. Herbs, if they claim to cure, become medicines which require manufacturers, wholesalers and importers to obtain licences. However, if their purveyors make no medicinal claims and if they are not listed “on the Herbal, Homeopathic, General Sale, or Prescriptions Only lists, ...” they are sold freely as vitamins and foods. Eighty percent are in this category and are governed by the regulations of the Ministry of Agriculture Fisheries and Foods. Food regulations are designed to ensure that products are uncontaminated and correctly labelled (Fulder, 83).

¹⁰⁴An unusual practice in Great Britain is to allow complementary practitioners to write sickness certificates to the Social Security Office and even to sign death certificates. This last concession is rare (Fulder 77-78).

¹⁰⁵Although homeopathy claims to cure many medical conditions, few homeopaths would recommend it exclusively for cancer, as just one example. It is therefore difficult to see how it can be seen as “complete”. In cancer treatment, it is more likely to be used as an adjunct to chemotherapy and radiation.

Education and Training

It is important for the consumer to know how well a practitioner is trained and how effective her treatments are, otherwise information necessary for consent is incomplete.

Standards of education and training are an intrinsic part of general certification and an acceptable level is crucial both for public recognition and public safety. An important issue in training is the level of medical knowledge required by alternative practitioners. Some schools require no basic science;¹⁰⁶ others, like the Canadian College of Naturopathic Medicine, require prospective students to have successfully passed a pre-medical undergraduate science program. Fulder asks how much medical science a complementary practitioner needs to know. He argues that while some knowledge is necessary, conventional doctors seem to be demanding a level of knowledge similar to their own. This, he says, has more to do with maintaining the “biomedical paradigm” than with concerns about safety (Fulder, 1996, 61-62). In spite of these objections, it seems that alternative therapists need to have sufficient medical knowledge to diagnose, to know when to refer elsewhere, and to understand a doctor’s medical diagnosis. They also need to know about drugs and how they interact with remedies the practitioner prescribes (Fulder, 62). Professional groups suggest that, at the very least, alternative practitioners should have a BSc in health sciences and a minimal knowledge of anatomy (Genest, 1993, 22).

Stephen Fulder says that no laws can prevent incompetence in either conventional or alternative medicine. All that legal licencing can do is ensure that the practitioner has an

¹⁰⁶The author tested this by inquiring of a college of homeopathy if her degrees and diplomas in literature, theology and religious studies, and no science, would be sufficient for entry. They were.

acceptable standard of training. A licenced medical doctor can become incompetent by failing to keep up to date. Because in many jurisdictions most alternative medical therapies are not formally licenced, no universal or even national legal requirement for an acceptable level of training exists. Fulder believes that the fear of incompetent alternative medical practitioners may be overrated, however (in his Threshold Survey he found only four untrained practitioners out of 137). "Competence," he says, has become a word usurping "'proof of efficacy' as the passport to legitimacy." Since the 1993 report of the British Medical Association, the requirement for competence is "tied in with the drive for education and standards" (Fulder, 1996, 64-65).

The move to greater professionalization is all part of a striving for competence. But how do we define competence and who is in a position to pass judgement (Fulder, 1996, 65)? Fulder says that few will have problems with the usual professional requirements that practitioners be accountable, offer honest information, make appropriate referrals and adhere to codes of ethics. Competence, however, "is usually defined according to the responsibility for outcome," and herein lies a problem. Fulder claims that "invisible qualities are much more important in alternative medicine, technical qualities in conventional medicine." He believes that biomedicine would judge competence according to concepts very different from those used by the practitioners of alternative medicine. Fulder claims that biomedical practitioners believe that because alternative medicine is "mild" and offers uncertain benefits, risks should be less acceptable. But, Fulder asks, "is it really more risky to be less interventionist? To reduce competence to the tangible and the measurable is what has happened to conventional medicine and is why there are alternatives in the first place. Competence of alternative therapists is also being defined today as knowing limits, [i.e.]... knowing when to refer patients to doctors" (Fulder, 1996, 64-65).

Stone and Matthews point to a view that they say is becoming somewhat more common in biomedicine -- a demand that all complementary health care providers study anatomy and physiology. This is consistent with the trend in schools of complementary medicine to provide such courses. They add that, in the past, when no one was discussing the regulation of complementary and alternative medicine, physicians opposed to CAMs demanded tighter control. They are now reversing their argument to maintain that "the law should not be used to legitimize scientifically invalidated therapies (Stone and Matthews, 1996, 111).

Training in Canada

In Québec, acupuncture is taught by non-physicians at Collège Rosemont. Chiropractic is taught at the Université du Québec à Trois-Rivières. University medical schools may include information on alternative therapies as part of a course but only the medical school at Queen's University answered "yes" to the York University researchers' question "Are you aware of any full courses on complementary and alternative medicine in your institution?" The University of Montreal and the University of Laval offer some courses in homeopathy to pharmacists. University nursing programs also offer courses full courses on complementary and alternative medicine¹⁰⁷ (York University, 1999, 242, 229, 231-232). While medical schools do not train doctors of complementary and alternative medicine, the federal minister of health announced in April 2000 a hope that certain types of courses in complementary and alternative medicine could be offered through McMaster University medical school in Hamilton, Ontario (Harris, May 2, 2000, A8).

Training programs are more frequently found at community colleges. A program in naturopathic nursing is offered to registered nurses at Centennial College in Toronto. Other

¹⁰⁷L'ordre des infirmières et infirmiers du Québec recognizes Therapeutic Touch, biofeedback, relaxation techniques, massage and visualization (York University, 1999, 228).

community colleges and post-secondary institutions offer certification in complementary and alternative therapies (Douglas College, New Westminster, BC; Grant MacEwan Community College, Edmonton, Alta; The Michener Institute for Applied Health Sciences, Toronto, Ont.) (York University, 1999, 232, 235-236). In Québec, Vanier College in Montreal offers courses that allow students to become certified Reiki practitioners or aromatherapists certified by the Mitchell Institute of Complementary Therapies (Vanier course catalogue, Fall, 2000). However, in Québec, most training in alternative therapies is conducted by private enterprise. While some training may be excellent (for example, the Canadian College of Naturopathic Medicine in Toronto, in which some Québeckers have studied, is structured like medical school), training functions within a system that (a) believes in its own methods and (b) falls outside the accreditation system which governs public institutions. Hence standards of training can be highly inconsistent.

One cannot overestimate the need for training. Poor training means that the practitioner will make mistakes in diagnosis or treatment or may not even know about risks. Across Canada, little consistency exists in the way that alternative medical education is governed. Some practitioners have extensive training; some know so little about science and the human body that they are dangerous. The client of alternative medicine must exercise caution. A naturopath may have four years post BSc training at the Canadian College of Naturopathic Medicine and call herself “doctor”. Or he may have taken an eight-weekend training course. Ironically, an MD who has taken a short training course in homeopathy is permitted to prescribe homeopathic remedies whereas the alternative practitioner with years of training but no medical degree is, in many jurisdictions, suspect.

Training problems specific to Québec

In Québec, many schools offer instruction with no quality control which explains the great

disparity in the training of alternative therapists. Martel points out that one can find alternative practitioners trained in Europe or the rest of Canada with what he describes as very grand titles. However, it can be difficult to find out if these titles reflect a high quality of teaching (Martel, 1992, 63).

An article in the popular alternative health magazine *Guide Ressources* (Lamontagne, 1992, 33-43) describes an alternative medical field which abounds not only with conscientious and well-trained practitioners but those who receive as little as 300 hours (also see *Office des professions*, May 1991, 2.2.6, 13) of training on top of nothing more than a high school education. A person who uses the initials N.D. (Doctor of Naturopathic Medicine) after her name, may have graduated from a full-time, four-year program after receiving a BSc (or BA with biology, chemistry and organic chemistry). In Québec, some use the designation Naturopathe Diplôme (n.d.) which could mislead the public into believing that they are doctors of naturopathy when they have received as little as eight months training, perhaps by correspondence (private communication with Ontario-trained Québec naturopath, May 1993). One might even be able to call oneself a homeopath after a few weekend training courses according to an article by Françoise Genest (Genest, 1993, 22). Those with thousands of hours training, and those trained over a few weekends (as long as those programs permit the graduate to belong to an association), may both offer services which insurance companies reimburse, conveying an illusion of legitimacy which may not be justified.

According to Christian Lamontagne, the great variations in the quality of the training schools and professional associations are due to the fact that alternative medicine in Québec is largely unregulated. Some associations, he says, are nothing more than facades allowing therapists to issue receipts which insurance companies reimburse. In Québec, the Ministry

of Health, the Ministry of Education, the *Office des professions*, and university researchers do not evaluate the quality of training that the associations of alternative practitioners recognize (Lamontagne, *Rapport annuel 1996 du Répertoire Santé*, Répertoire Santé Électronique, <http://totalmedia.QC.ca/repante/aasgen/rapp 1996.htm>, partial Trans. O'Rourke).

The *Loi sur l'enseignement privé* covers private institutions which teach most alternative therapies in Québec. To teach these subjects, the private colleges must obtain a permit from the Ministry of Education. Under current law, two categories of permit are possible: a permit for professional teaching and a permit to teach personal culture (Martel, 61-62, Trans. O'Rourke), for example short-term massage courses or colour therapy.

Professional teaching is, according to the law, that which has as its immediate goal preparation for the exercise of a profession or trade ("qui a pour but immédiat de préparer à l'exercice d'une profession ou d'un métier" (*Loi sur l'enseignement privé*, art. 1 (b)).

Alternative therapies are not professions according to the *Code des professions* and therefore instruction in alternative therapies is not considered to be professional training. Requests for permits are referred to the *Office des professions* which, according to Martel, systematically reject them. He maintains that this office yields to the influence of the Collège des médecins, which does not approve of any teaching which could lead to the practice of medicine without a licence. Martel holds the Collège responsible for the deficiencies in the training of alternative therapists in Québec (Martel, 1992, 62-63).

Because of all these limitations, alternative therapies and their training schools are, in Québec, governed only by the *Loi sur la protection du consommateur*. An advertisement for the Institut NHC (The Natural Health Consultant Institute) in Notre Dame de Grâce, on

the borders of Montreal, is fairly typical of the private schools. Institut NHC claims that “any illness or misfortune is an opportunity inviting us into the Great Healing Journey” (Hamilton, 2000, NHC curriculum, Introduction). The school’s 1500 hour diploma program qualifies people as certified wholistic practitioners specializing in naturopathy, massage/bodywork or psycho-energetic consulting. Recent offerings (Spring 2001) include courses in “Awakening Intuition” and “Spiritual Psychotherapy”. Its programs reveal how closely alternative medicine and spirituality are linked. The Monday night lecture series, for example, opens with a program “Beyond Duality” which will discuss “Duality as a source of human suffering” and “Transcending the duality of manifestation to the oneness in divine consciousness” (advertisement, Montreal Gazette TV Times, April 21-28, 2001). To its credit, the school also offers programs in ethics and professional behavior.

Training in Great Britain

The 1993 BMA report, according to Fuller, led to a concentration on accreditation and standards and left scientific verification to one side. Lay homeopaths now teach anatomy and other biomedical subjects which Fulder describes as “previously unthinkable”. Professionally trained and registered therapists, he says, attempt to keep a distance from those who are untrained but who are still permitted to practice under British common law (Fulder, 1996, 53-54). Fulder points out that as the schools become more professional they evolved, just as modern medicine did. Modern medicine was once a teacher-apprentice system and its different colleges varied in their standards and ways of teaching. The tendency to professionalize, he claims, has unified the field of alternative medicine just as, approximately one hundred years ago, it unified conventional medicine. Consequently, alternative medical training in Britain has become more homogenous with “precisely delineated teaching sequences, producing similarly trained practitioners, of reasonable competence and deep-seated conservatism” (Fulder, 54). Alternative therapists are now

judged on qualifications, not results, he says, which robs alternative medicine of flexibility in training and assessment. Fulder believes that as the field becomes more professional, its strengths and “adaptive and unconventional healing strategies -- will be crushed. Then alternatives to the alternatives will be needed and will no doubt arise” (Fulder, 54).

The old alternative medical training system in Great Britain was conducted by private colleges. Fulder describes them as being true to their tradition but often “inward-looking” and “idiosyncratic”. Nowadays, state registered chiropractic is mainly taught in the Anglo-European College of Chiropractic which offers a four year course similar to those of medical schools and leading to a BSc. Osteopathy is taught in four- year full- time degree status courses accredited by the General Council and Register of Osteopaths. Degrees are also available in herbalism. Middlesex University offers a four-year full time course which grants a BSc. Honours in Herbal Medicine (Phytotherapy). Supervised practice after the training is available. Acupuncture and homeopathy are taught as complete medical systems in the private system and at the college and university level (Fulder, 1996, 56).

While a European directive recommended that training in alternative therapies should be given in programs equivalent to three years of third-level education, therapies can be taught, under common law, by anyone (EU Directive:CD/89/48/EC, in Fulder, 1996, 56). This is why one can find in Great Britain, as in Canada and the US, short courses, some of which are offered by correspondence schools. However, as Fulder points out, when a therapy is taught in a three- year college or university program, it is clear that the subject requires the student to devote this amount of time to learning his profession. Consequently schools with less stringent requirements will be perceived to produce less reliable practitioners. Subjects like aromatherapy or reflexology, however, do not need extensive training. Furthermore, many of the complementary therapies offer short self-help courses for the lay public

(Fulder, 1996, 55-57). Research is now encouraged by the British Medical Association and, though Fulder argues that this “implies developing a biomedical view” even he sees its utility. Complementary and alternative medicine is also studied as a general subject. The University of Exeter and the University of Westminster offer postgraduate courses in complementary studies (Fulder, 57).

Training in the United States

In the United States a number of physicians and scientists have strongly objected to university medical schools offering courses in complementary and alternative medicine. However, an increasing number of American universities incorporate survey courses on complementary and alternative medicine within their faculties of medicine and programs have also been set up to conduct research. As noted in chapter one, academic interest in the field is growing.

Training programs and professional associations

In 1995, the group *Répertoire Santé* (founded in Québec in 1991) created an advisory committee made up of three people knowledgeable in the field of alternative therapies: the former president of *l'Ordre des infirmières et infirmiers du Québec*; Me Paul Martel, a lawyer and author of *Attention Santé* who is also the former president of *la Coalition-Réseau alternatif de santé du Québec* and the director general of the *Fédération québécoise des masseurs et massothérapeutes*. The advisory committee was mandated to come up with criteria to evaluate the training that the professional associations of alternative therapies recognized and to see how well the disciplinary committees and codes of ethics of these associations protected the public. The group studied training programs but realized, after studying many documents, that the most realistic way to proceed was to analyze the codes of ethics. They concluded their study by simulating a client complaint (*Répertoire Santé*,

annual report 1996).

Among their observations were the following:

1. Public and private institutions lack resources to evaluate the level of protection or training offered to the public by groups of alternative therapists.
2. Training programs conducted outside universities are frequently unable to guarantee that what they offer corresponds to recognized standards of knowledge. Often, these schools claim to be recognized by a particular association but neither the schools nor the associations have been evaluated objectively. The associations do not necessarily evaluate those they admit as members.
3. Those who teach internationally recognized techniques such as Rolfing or Feldenkrais adhere to rigorous international standards.

(Lamontagne, Répertoire Santé annual report 1996).

Martel makes some concrete proposals for designing training standards. Two types would be created: general standards which would be imposed on all certified therapists, and norms specific to a particular practice. General standards could include ensuring that therapists have:

1. Knowledge of anatomy, physiology and pathology sufficient to be able to detect the presence of disease or serious conditions which require medical treatment so as to reduce the risk of 'losing one's chance' to be cured. Therapists should know what official medicine can offer.
2. An introduction given on all approaches and techniques available in the field of alternative therapy, with their benefits and limits, in a way which favors interdisciplinary collaboration.
3. Information to help the therapist to understand the personal beliefs and values of clients.
4. A basic knowledge of the factors which create and preserve health.

5. A basic knowledge of such aspects of professionalism as ethics, law and relevant regulations (Martel, 169, Trans. O'Rourke).

Particular standards, which would vary according to each discipline, would be controlled by the groups responsible for control of this system and these groups would raise the standards over time, depending upon the availability of qualified instructors. In some fields, international standards have been developed to which the Québec groups would adhere (Martel, 1992, 169).

Martel concludes by pointing to the dangers of an overemphasis on scientific rigour where it ignores the qualities of “empathy, intuition and humility”. He believes that training must devote considerable time to developing these human qualities (Martel, 169-170, partial trans. O'Rourke).

Codes of Ethics

All hospitals and health care institutions in Québec are obliged to have a code of ethics. Such codes are now common in many fields -- business, universities, professional associations. Many groups of alternative therapists have produced such documents. For example, following the recommendation of the *Office des professions* about alternative therapies, *l'Association des diplômes en naturopathie du Québec* created a code of ethics (York University, 1999, 229). Codes of ethics set standards against which a practitioner, in a lawsuit, might be measured. Codes can be seen as educational or legal documents, as a set of ideals, or as specific obligations.

Most self-regulating bodies develop codes of ethics to guide practice. In Stone and Matthews words, they are “normative instruments, attempting to influence behaviour.”

Although the word “ethics” (or *déontologie* in French) appears in their titles, Stone and Matthews argue that codes do not usually ground the various requirements in the corresponding ethical principles. Hence respect for confidentiality will be insisted upon but will not be based on the principle of respect for autonomy. Some codes state that sexual contact is prohibited but this is not grounded in the duty not to harm. The codes make clear what the particular profession’s values are but do not state all the ethical principles with which practitioners should be familiar. For example, Stone and Matthews say, most codes do not usually deal with the concept of truthfulness or of the requirement, under justice, to make clients aware of how they may complain. In other words, they say, most codes are written for professionals without the involvement of the consumer (Stone and Matthews, 1996, 194-195).

Stone and Matthews are writing in the British context. A perusal of a handful of the codes of ethics of various Québec-based associations of alternative practitioner, and one from Ontario, reveals a strong focus on truthfulness, including a requirement by one association that the practitioner tell her client about any “préjudiciable” errors (Code de déontologie of La fédération Québécoise des masseurs et massothérapeutes, 30 mai, 1993, 3.02.08). Nonetheless, Stone and Matthews’ assessment is a fair one. If the requirements are not grounded in ethical principles, then they are nothing more than rule-books and do not enable the practitioner to go beyond the requirements to consider the spirit behind the law.

Stone and Matthews state that users of complementary medicine are rarely invited to collaborate in the design of codes of ethics and lay membership of disciplinary committees is rare (Stone and Matthew, 1996, 195). The same could be said of codes designed for medical doctors. However, codes of ethics provide a method for ensuring adherence to “appropriate standards of practice” where statutory provisions are absent (Stone and

Matthews, 204). Ultimately, Stone and Matthews believe that, for teaching purposes, instruction in ethical standards (and principles) is more important than codes of ethics, some of which do not even emphasize obtaining informed consent (Stone and Matthews, 208).

Codes of ethics are not, in themselves, a guarantee that practitioners will behave ethically. They do, however, raise awareness and function as educational tools for all types of professionals. They tell clients what they may expect. However, as Stone and Matthews say, they will only be effective if the practitioner has thoroughly imbibed ethical principles during professional formation. A code can only summarize general requirements. Stone and Matthews do not recommend including legal responsibilities in a code of ethics as that tends to reinforce the view that one adheres to a code of ethics to avoid lawsuits (Stone and Matthews, 1996, 205).

Martel thinks that codes of ethics should be backed by law to give them “teeth” (Martel, 1992, 166-169):

The Coalition -Réseau alternatif de santé du Québec imposes on all its members a similar general code of ethics, but it does not have the power to discipline therapists who violate the code of practice. All it is able to do is to expel the therapists from the Coalition. A code of ethics, no matter how strict, has limited value if the therapists cannot be sanctioned by having their licences suspended or being forbidding to practice. That is why statutory support is necessary (Martel, 1992, 166, Trans. O’Rourke).

Martel says that alternative practitioners must be held to the same norms as conventional health care professionals. Laws and regulations oblige all therapists to adhere to minimal standards of practice and ethics to assure the public of protection: These norms include:

1. The obligation to give the client complete information about the therapist’s credentials and experience.
2. The obligation (although this is not an absolute requirement in all provinces) to ask the client to sign a consent form which not only states the client’s rights but indicates to him, for example, the

risks, benefits, limits and contraindications of the proposed therapy... .

3. The obligation to retain all patient files in a confidential manner and make them accessible to the client [as is the case in Québec hospitals and doctors' offices].

4. A list of the provisions governing the therapist's professional conduct, in other words, a code of ethics. This code would cover personal behavior, publicity [i.e. ethical advertising], hygiene [if equipment is used, how is it sterilized?], standards for collaborating with other therapists [or physicians], fees received [honoraria from suppliers for example], professional secrets. (Martel, 1992, 166, Trans. O'Rourke)

The Coalition-Réseau alternatif de santé du Québec's code of ethics has more than fifty clauses. It includes, under the section *Obligations to the Public*, the requirement to abstain from giving false information. Under the section *Obligations to the client*, the therapist must abstain from any form of coercion and know the limits of his skills. Under the section on *fees* Martel lists a number of mechanisms which ought to prevent commercial fraud: not asking for payment in advance, not claiming for services not rendered. Under *Responsibilities to the Profession* the professional is told to abstain from abusing alcohol or drugs; to avoid falsifying insurance documents for the client; to avoid denigrating any other therapist or physician; to avoid claiming that he/she cured someone when someone else was in fact responsible. Under *Responsibilities to the Corporation* (that Martel hoped would be created) the therapist is to inform its officials if he performed his work incompetently. Under *Records and Professional Secrets*, all records and information are to be confidential and available only to the client and anyone else the client authorizes (this is law in the official health care system). However, members of the corporation, if legally authorized, would be able to consult the chart. Under *Forbidden Acts* the therapist is not to perform surgery or penetrate tissues (except for acupuncture and, in certain types of therapies, looking into the ear, mouth or rectum). He must not use ionizing radiation in a toxic dose nor prescribe drugs he is not authorized to prescribe. He is to refuse to treat diseases diagnosed by medical doctors (for example, sexually transmitted diseases or contagious diseases) unless he has received a referral or is supervised by a physician or in cases where

medical treatment has proved ineffective. He is forbidden to practice a therapy which can only be practiced by someone with a reserved title (chiropractic for example). If he contravenes the code, he must be suspended temporarily or for life (Martel, 291-298).

The group *Repertoire Santé* studied the codes of ethics of twenty-seven associations.¹⁰⁸

¹⁰⁹ For the analysis, 15 elements were considered important for the protection of the public.

These were:

1. a definition of sexual harassment
2. a clause forbidding sexual harassment
3. a clause forbidding work outside the therapist's field of competence
4. a clause forbidding the therapist to propose unnecessary treatments
5. the obligation to refer the client to another professional if the client's needs required it
6. a clause forbidding psychological manipulation

¹⁰⁸The team read each code to see if it contained clauses which explicitly covered each of the fifteen items. It also made anonymous inquiries to see how each association responded to complaints. The team found a great disparity between the codes of ethics of the different associations of practitioners of alternative medicine. While some covered all important elements, others were woefully lacking. The team discovered that the well-established associations with many members were the most likely to have codes of ethics and complaint procedures (Lamontagne, 1996, annual report).

¹⁰⁹Some codes of ethics of alternative practitioners give detailed advice on how to ensure that the client is respected. For example, the *Code de déontologie of L'association des naturopathes de Montréal* (mai 1992), and that of *La Fédération Québécoise des masseurs et massothérapeutes* (30 mai 1993) instruct the practitioner to respect free choice, confidentiality, honour the right of the client to refuse treatment or consult someone else. The massage therapy association instructs practitioners to respect a client's personal convictions and asks that the practitioner make sure that the client has access to her file. Some make general recommendations that the individual practitioner needs to learn to apply. For example, the code of ethics of *La fédération Québécoise des masseurs et massothérapeutes* says that the the massage therapist is neither to practice in an impersonal manner, on the one hand, nor, on the other, do anything that would lead a client to become emotionally or sexually dependent (3.01.05a; 3.01.06a). This organization's code is extremely comprehensive, spelling out in detail what the practitioner must do to ensure that the client is respected at all times. It even insists that the practitioner must ensure that she is emotionally and sexually balanced, never using clients for her own satisfaction and quickly seeking help if she feels vulnerable (3.04.02;3.04.03). In general, these articles of the code seem not to be written to serve the self-interests of the profession. They focus clearly on the client's right to freedom from coercion and remind practitioners of the obligation to prevent harm.

7. a clause forbidding the therapist to promise to cure the client
 8. a clause obliging the therapist to inform the client about the nature of the treatments proposed
 9. control over the sale of products
 10. control over the promotion of products
 11. the obligation to respect the client's values
 12. provisions for protecting client charts
 13. a complaint procedure
 14. the welcoming of complaints
 15. the determination of sanctions against therapists who do not comply with the code.
- (Lamontagne, 1996 annual report, Répertoire Santé, Trans. O'Rourke).

While the *Coalition-Réseau alternatif de santé du Québec* and *Repertoire Santé* offer comprehensive guidelines, the thinking of both suffers, to some extent, from a perhaps excessive focus on legal requirements and legal sanctions. Neither organization grounds the obligations in ethical principles and theory. Stone and Matthews recommend an approach that emphasizes “good therapeutic practice” rather than a “negative list of prohibitions.” This, they say, will “reinforce practitioners’ training as to what constitutes ethical practice.” They add that the groups that regulate the professions ought also to provide an ethics consult service for its members (Stone and Matthews, 1996, 280-281).

Should a code of ethics be enforced by legal sanction? As normative statements, Stone and Matthews say, they can only tell practitioners how they should act; they cannot enforce good behaviour (Stone and Matthews, 1996, 205). Good codes need to identify what ethical behaviour is and should promote high standards. “A sound ethical base is at the heart of safe and competent practice” Stone and Matthews say (Stone and Matthews, 208). Nonetheless, sanctions applied to therapists who behave in a way contrary to high ethical standards are an important aspect of protection of the public. Codes of ethics can be enforced by professional associations, but, without laws behind them, codes of ethics are not enforceable (see Stone and Matthews, 206).

Conclusion

The Canadian publicly-funded health care system, according to many, is in a serious trouble. The demand for medical care appears to be increasing but money to fund it is scarce. However, some governments and medical administrators have chosen to see the crisis as a challenge. Hospitals built to serve nineteenth century needs are being re-configured to reflect radical changes in the way in which medical care is delivered.

The evident crisis in health care presents a challenge and an opportunity to re-think the entire biomedical enterprise. It is at this point that alternative medicine might make important contributions. In some countries, it is borrowing its organizational structures from the biomedical model. A new generation of medical students is demonstrating some cautious interest in alternative medicine and, as we have seen, some medical societies are attempting to build bridges to the alternative world. It is too soon to tell whether or not Canadian medical societies and provincial organizations are ready to collaborate more closely with the practitioners of alternative medicine but when they do, the positive freedoms of the public will be enhanced by increased choice and a greater assurance that all forms of medical care are safe and effective. Some people believe that complementary and alternative practitioners offer a form of care that is more benign than that of conventional medicine and more respectful of the patient/client as a whole person. This is not necessarily the case. But regulations to govern the safety of alternative products and to ensure that alternative practitioners are well-trained, competent and ethical will go a long way towards honouring the principles of non-maleficence and beneficence.

Chapter Eleven

Justice and Complementary and Alternative Medicine

The Three Types of Justice

Thomas Aquinas, in the *Summa Theologica*, speaks of two kinds of justice: commutative justice, which is the justice of direct exchange, and distributive justice, in which each person is given what his “rank deserves.” Both are part of original justice, the root of which is the “supernatural subjection of the reason to God” (Aquinas, *Summa*, Vol I, Question 21, art 1, 223; Question 100, art 1, reply to objection 2, 939). Justice is a cardinal or hinge virtue and governs relationships between equals and unequals.

This chapter will examine complementary and alternative medicine under Aquinas’ two categories but it will begin with a third, adjudicatory (Frederick B. Bird’s term, 1999) or retributive justice.¹¹⁰

Adjudicatory/Retributive Justice

Adjudicatory justice refers to the way in which aggrieved or injured individuals can make, resolve and settle complaints. A good adjudicatory system makes it possible for people to have their complaints heard, allows for due process, allows individuals complained about to defend themselves, allows evidence to come forward. Its mechanisms may include mediation which reconciles warring parties all the way to the criminal justice system, in which severe disciplinary measures can be enacted against wrongdoers. The aim of adjudicatory justice,

¹¹⁰Although, as noted on page 70, there are multiple viewpoints on justice, i.e. libertarian, liberal, utilitarian, liberationist, for the purposes of this thesis, justice will be divided into these three categories.

depending on the case, could be reconciliation, restitution, loss of licence to practice or incarceration. This section will examine the most common mechanisms by which adjudicatory justice monitors the practice of medicine: complaint and disciplinary systems and sanctions. The principles behind these mechanisms apply as much to complementary and alternative medicine as to biomedicine, but regulations governing biomedicine are consistent across the country and have a longer history.

Complaint and disciplinary systems

Internal Mechanisms in Conventional Medicine

A number of mechanisms exist to govern the field of conventional medical and health-care professional practice and to allow complaints about poor practice or malpractice to come forward. Within hospital institutions, various councils include disciplinary committees. Patients and professionals may bring to these bodies complaints of suspected wrongdoing.

The Québec Government enacted its complaint system (Bill 120) in 1993. Since that date, all hospitals and health care centres must comply with an elaborate procedure that ensures that patients' complaints are responded to quickly and that a report detailing types of complaints and interventions made is sent annually to the Regional Board of the Health and Social Services system. Each institution must appoint a person who is accountable to the institution and to the government for the way in which complaints are investigated and resolved. Procedures for complaints about medical acts, governed by Art 38, Bill 120, are particularly stringent. In each institution, such complaints must be investigated by the Council of Physicians, Dentists and Pharmacists.

Hospitals have other mechanisms such as morbidity and mortality rounds to control the medical acts that take place within the institution. Such activities serve to keep physicians

aware of how well or badly they performed in a specific case and serve to teach physicians how to give better care in future.

External Mechanisms in Conventional Medicine

Québec probably leads the country in the seriousness with which it views patient complaints and the rigour with which it applies the law so as to make sure that patients are dealt with honestly and promptly. In 1993 it created two government organizations to oversee the complaint handling system in each institution. Anyone who is dissatisfied with the way in which a hospital or health care centre handles or responds to a complaint about non-medical matters (i.e. about a nurse) may request a complaints counsellor at the Regional Board to re-investigate. If the person feels that the regional board dealt with the complaint improperly or ineffectively, he or she can appeal to the Commissioner of Complaints who is mandated to act by the Québec government.

Appeal mechanisms serve to protect patients from the natural tendency of departments and institutions to protect their own. As well as the government agencies that hear general complaints, patients have recourse to the professional associations. For example, the Order of Technologists of Québec, and all other professional orders, have a “syndic” who is the person charged with investigating complaints about members. Appeals about the way in which an institution investigated a complaint about a medical act may be sent to the Québec College of Physicians. In fact, the College of Physicians in each province receives complaints about physicians and can take disciplinary action if necessary.

With such an abundance of systems to hear complaints, patients can ask to have their complaints investigated free of charge and then proceed to a lawsuit only if it is clear that they have a reasonable chance of winning it.

Complaint and Disciplinary Systems in Complementary and Alternative Medicine

Similar mechanisms do not exist in the field of complementary and alternative medicine.

Consumers can complain to the governing body of a regulated alternative profession such as chiropractic or acupuncture and, if the damage is sufficiently serious, the practitioner may have his licence suspended or withdrawn. Unfortunately, many CAMs are not licenced. A professional association may have the power to cancel a member's registration or certification but this will not prevent the member from practicing (Harden and Harden, 1997, xvi). Redress would only be available if the law were broken through fraud, injury or death. Codes of ethics, discussed in the last chapter, also act to control professional behavior but, in many cases, they are guiding principles without legal authority. However, breaches of codes of ethics would likely be dealt with by professional disciplinary committees.

Clients can sue in the civil courts for damages involving fraud and through the criminal courts for negligence or battery. Anyone suing for negligence will have to be able to prove two things: (1) that the practitioner was in breach of a duty recognized by law and (2) that the health professional's intervention is the proximate or direct cause of material injury to the client. In addition, the client must not be guilty of contributory negligence or be open to a charge that she voluntarily assumed the risk (Langlois, presentation at conference *Complementary Medicine in the Mainstream*, 1998, November 24).

In terms of health care products, the federal government is responsible for the administration of the Food and Drug Act and may act against anyone selling an unapproved product or placing a prescription drug on open shelves.

Harden and Harden note that more and more alternative practitioners are purchasing liability

or malpractice insurance and some associations make such coverage mandatory. However, malpractice suits against complementary and alternative practitioners are difficult to resolve as, in many cases, no consistent standards of practice exist against which to measure a member of an unregulated profession (Harden and Harden, 1997, xvi). This, however, might not be applicable to highly regulated professions like chiropractic.

While most people taking a health care professional to court are acting because of injury and death, and therefore suing for negligence, some may feel themselves to have been psychologically injured. If a person has joined a healing group that turns out to have been coercive and damaging, he or she can sue the leaders in civil or criminal court, depending on the case. Furthermore, just as medical groups have their own licencing associations, some leaders of healing groups are ordained ministers in a particular church. The church can therefore be appealed to to impose sanctions.

Stone and Matthews point out that, in spite of complementary and alternative medicine's lack of regulation, very few clients bring lawsuits against alternative practitioners. It is not fear of lawsuits that is behind the growing trend of alternative practitioners to organize themselves into professional groups (Stone and Matthews, 1996, 77-78) but, probably, a desire for professional self-regulation.

Few people, in fact, appear to complain about alternative practitioners. Dickinson in England points to a survey by *Health Which?* which found only three percent of people complained about alternative practitioners. The author and his team discovered that, out of thirty-three people, few checked a register before making an appointment with an alternative practitioner and only two made formal complaints. The British Complementary Medicine Association said it had not received any complaints (Dickinson, 1996, 157). In the United States, from

1990 to 1996, David Studdert and his co-authors write, fewer claims were made against alternative practitioners and the claims that did exist were for injuries less serious than those for which physicians were sued (Studdert et al., Nov 11, 1998, 1610).

In 1996 the group called *Répertoire Santé*, invited the dissatisfied public to use the *Service d'écoute et de référence du Répertoire Santé* so that those unhappy with the care offered by members of associations not governed by the *Office des professions du Québec* could complain. The service promised to refer the person making the complaint to the relevant association and follow the investigation to ensure that the association followed correct procedures (*Répertoire Santé électronique*, Totalmedia, Toile du Québec, December 1997). This association can no longer be found on the internet and the phone number is out of order.

Sanctions

Sanctions are often sought by those who feel injured. Complaints or lawsuits could be seen, according to Bird, as “culturally transmitted symbolic codes” which fulfill the requirements of ritual in that they are stylized and, in the courtroom, “dramatically structured”. The mechanisms to resolve a formal complaint to a health care institution in Québec, or a lawsuit anywhere in Canada, will have more power than an informal, customer-service type of complaint system because of the authority with which government and the courts are invested. These rituals are important because they contain the strong emotion that accompanies a sense of injury, loss or betrayal -- all common reactions when a person is hurt by a medical professional. A person who feels sick or weak usually has no choice but to place his trust in a healing professional. When the trusted professional injures, the patient's anger and grief can be uncontrollable. Complaint mechanisms and official sanctions act as mechanisms by which society recognizes the injury and offers a token to

assuage the hurt and angry feelings. The token may take the form of a letter of apology, a personal meeting with senior staff or payment, either out of court or as the result of a lawsuit. In cases of severe injury or death, financial compensation is needed for practical reasons. Lawsuits, in particular, have a kenotic aspect in which anger is discharged in ritual form, leaving the person free to continue with his normal life (see Bird, 1980, 388; Vogel and Delgado, 1980, note 167, 84; O'Rourke, 1992, 134).

Lawsuits may also be made against individuals for practicing medicine without a licence, a common charge against alternative practitioners. These suits are usually brought by members of the medical profession who may feel an obligation to protect the public against "charlatans". In some cases, a client or a client's relative takes action, often when an intervention has resulted in death.

Lawyer Paul Martel says that the public is not well served when complementary and alternative practitioners are pursued for the illegal practice of medicine. His proposed structure of registration and certification would establish a series of appropriate sanctions:

1. Therapists who do not register or become certified in conformity with the law, or who continue to practice after being struck off, would automatically be subject to penalties.
2. Therapists, registered or certified, who contravene the norms of practice or code of ethics of their professional group could be struck off the register or lose certification and would have to make restitution.
3. Certified therapists who contravened the disciplinary norms of their own associations would be suspended or struck off.
4. The public would be invited to lodge complaints against therapists with the responsible authorities in the system and would be able to count on rapid and impartial action. (These complaints would be studied by a disciplinary committee) (Martel, 1992, 171-172, trans. O'Rourke).

Martel's suggestions are excellent ideals to which professional groups may aspire. An important addition would be the inclusion of professionals from ancillary professions.

Naturopaths could work with the *syndic* of an association of homeopaths and laypeople should be included in hearings and disciplinary committees. A weakness of the Québec system that controls medical acts is that non-physicians are rigorously excluded from hearings, even at the hospital level (article 38, bill 120). A system that includes laypeople will not only appear more open and honest, it will actually benefit from other points of view.

Distributive Justice

Distributive justice refers to just allocation of goods, to effective utilization of goods and to information about those goods. In health care, distributive justice covers discussions about access to care, questions about the minimal level of care all citizens should have by right and questions about gatekeeping to ensure that only those who need a service will have access to it. Good gatekeeping systems do not permit the frivolous (from the doctor's point of view) use of expensive equipment like CT scans. They are not available upon request. This section of the chapter will focus on access and public information.

Access and the Allocation of Resources

Access to alternative health care is not equitable in Canada because it is not insured via tax-funded state insurance. Some people are privately insured for alternative health care but many are not. The situation is similar in the United States where access is hampered by the health insurance plans chosen by individuals' employers. However, the significant difference between the two countries lies in the availability of tax-funded conventional medical care in Canada.

Once cannot discuss access to complementary and alternative health care in the same way that one looks at access to cancer therapies or heart transplants. Conventional medicine

usually treats life-threatening diseases and often has no choice but to use costly therapies. Complementary and alternative medicine is usually a low tech, cheaper way of treating chronic or short-lived conditions. The following will look at the question of state-funded and hospital-provided access, involvement of the pharmaceutical industry and private insurance.

State-Funded Access -- Medicare

The ethical issue of fair access to alternative medical treatment will probably arise when certain forms of that treatment are proven effective. If an effective treatment exists, ought it to be available in Canada under Medicare? A CTV/Angus Reid Group poll in August 1997 found that 70% of Canadians think that provincial health care plans should cover alternative medicine (CTV/Angus Reid Group Poll, August 1997). The problem, for health care plans, is that if a precedent is set in which ineffective or unproven treatments are covered, then the plan managers may be put in the difficult position of being required to pay for any treatment demanded by the client (York University, 1999, 66-67), a point the York University report makes about private insurance plans.

When changes were proposed to the British National Health Service in light of the demands of the European Parliament, the British Association of Holistic Practitioners hoped to gain access to the National Health Insurance Program. Only homeopaths and homeopathic hospitals had been welcomed under Aneurin Bevin's 1949 National Health Insurance Scheme. The alternative practitioners argued that nothing in the NHI plan excluded alternative medicine (British Holistic Medical Association in Saks, Ed., 1992, 247-249; 243). Fulder argues that the founding fathers of the NHS, by refusing entry to alternative medical practitioners other than homeopaths, restricted freedom of choice. In fact, it was only in 1974 that the General Medical Council allowed physicians to make contact with

alternative practitioners (Fulder, 1996, 88). Norman Gevitz points to the fact that when American unorthodox practitioners defended their right to practice in the early part of the nineteenth century, they equated the “right to choose their health care practitioner with freedom of religion” (Gevitz, 1988, 21). The right to choose is inhibited when one system is free of charge and the other is not.

In countries where health care is state insured, those who choose alternative medicine must pay for consultations, treatments and prescriptions. Some believe they might save the state money by using commercially available alternatives. However, this would not be so if expensive medical complications of alternative treatment needed to be treated conventionally. When the Québec Government in 1990 showed interest in accrediting certain types of alternative practices, it was not promising to include it in the medicare system. Government health experts probably realized that legitimating alternative medicine might help trim health care costs at the expense of the public and their insurance companies.

Early in 2000, Canadian federal Health Minister Allan Rock announced that he was considering placing some types of complementary and alternative medicine under medicare. At the same conference, Heritage Minister Sheila Copps announced a fund-raising drive for Canada’s first school of complementary and alternative medicine based in a university medical school (Harris, 2000, May 2, A8). Are these initiatives a sign that the federal government believes that Canadians lack fair access, or are they vote-attracting manoeuvres -- a distraction from the serious health care dilemmas faced by the federal and provincial governments? Government ministers risk breaking promises when they assure citizens that they will have timely access to conventional health care. Offering a popular alternative is cheap and implies that the minister is on the cutting edge, sensitive to current needs and responsive to demands.

A major ethical question is the extent to which public funds ought to be diverted to complementary and alternative medicine. Perhaps they could be diverted to those that have been proven to work more effectively and to save the state money. In Canada, public health insurance pays for the following treatments: British Columbia, Alberta, Saskatchewan, Manitoba and Ontario pay for chiropractic treatment and British Columbia also reimburses naturopathy. Chiropractic treatments are also approved by Workman's Compensation Boards, under certain conditions, in all provinces and the Yukon. Acupuncture is approved for the Workers' Compensation Board in Québec, Prince Edward Island and Yukon (York University, 1999, 51-56). However, according to an Angus Reid Group poll conducted for Health Canada in 2000, many of the members of the cross-Canada focus groups interviewed did not believe that unproven remedies and therapies should be covered by Medicare (CTV/Angus Reid Group Poll, in Aubry, 2000, August 8, A9).

Commercial Access in State-Funded Hospitals

Some hospitals have wondered whether they should enhance access to complementary and alternative medicine by offering it in-house. In some cases, the hospital may be attempting to keep a paternalistic/maternalistic eye on practices it fears may be otherwise injurious. A more cynical view holds that hospitals may wish to project a caring image by offering the latest in holistic treatment. They may also see in alternative practices a way to generate revenue for the institution in the same way that departments of psychology run clinics to help smokers, the obese or those who fear flying.

Allocating resources requires the exercise of justice in two directions: the obligation of the state to ensure access to certain types of health care and the requirement that the individual take responsibility for herself. Do we have the right to demand that the state supply all

health care needs? Some? Only those proven to prevent serious disease or to save life? A just model may be one in which the state provides resources but each citizen also assumes some of the burdens. Stone and Matthews cite D. Seedhouse who says that people interpret justice in health care in different ways. Some think it means giving people only “what they *deserve*,” others presume it to mean giving people what they need and a third group believes that justice is connected to supporting rights (Seedhouse, 1995, in Stone and Matthews, 1996, 267). Canadian society tends towards the model of providing what the government determines is needed. All members of society, even those with lifestyle- induced diseases (lung cancer, cirrhosis of the liver, HIV) are considered worthy of receiving basic medical care.

Access Through Pharmaceutical Companies

Pharmaceutical companies can ensure that those willing to pay for medication or an insurance plan have access to alternative remedies. However, problems can arise when these organizations “hop onto the alternative medicine bandwagon”. Like insurance companies, pharmaceutical companies see in alternative medicine a source of profit. Some, for example, now carry a line of herbal and homeopathic remedies. An article in a pharmaceutical journal exults: “for pharmacists willing to learn about this unique and sometimes controversial type of health care, that spells opportunity with a capital O, all four experts agreed as they addressed hospital pharmacists attending ASHP’s annual meeting last month in Minneapolis” (Cardinale, 1997). However, pharmacists may be motivated by beneficence. The author cites a pharmacist who believes that being able to offer homeopathic remedies gives pharmacists “an opportunity to practice holistic care to promote wellness” (Chapman in Cardinale, 1997).

Not all pharmacists are so enthusiastic. A question raised in the Hastings Center Report’s

Case Studies column asks whether a pharmacist should give information about how to obtain a homeopathic medicine to a patient who requests it. Some thought the pharmacist should simply give the information; others thought the pharmacist should withhold information, telling the patient it is ineffective; a third option would be to give the information but discuss its therapeutic uncertainty. The last option is the one most favoured by the commentators (who do not appear to have much confidence in alternative medicine) (Resnik and Resnik, 1989, May/June, 38-40).

The Ontario College of Pharmacists issued a policy to encourage its members to learn more about complementary and alternative medicine. Half of the members of Newfoundland's college are described, in the York University report, to have a "market-driven" interest in the subject. Major issues for pharmacists are a need to know about drug interactions between conventional and alternative remedies and, for those in commercial pharmacies, to have sufficient understanding of alternative products to give advice. The Canadian Association of Pharmacists believes that it is unethical to sell a medication about which they know nothing. Education on the subject varies across the country but may not be sufficient to meet consumer demand for expert help in this area (York University, 1999, 222-224).

Access Through Private insurance

Some insurance companies insure both alternative remedies and alternative treatments. Insurance for alternative health care is sold as an employee benefit by insurance companies anxious to attract more clients, keep up with consumer demand and remain competitive (see York University, 1999, 72). In their turn, companies offer such plans to employees as an enhancement to their basic insurance plan that may improve health and/or increase loyalty. The advantage to insurance companies is the relatively low cost of alternative medicine compared to conventional medicine. One might argue that this advances metaphysics over

science in the pursuit of health. When one considers that some Americans cannot complete a course of chemotherapy because of insufficient insurance, it seems meretricious that insurance companies show more interest in less costly and perhaps less crucial treatments while ignoring the most costly and (as biomedicine would argue) the most effective. Another objection on the part of conventional medicine is that commercial approval lends a spurious legitimacy to unproven treatments. "Reimbursement is destiny. Nothing in medicine is perceived as entirely legitimate until it's reimbursed" (Jerry Kantor in Goch, 1997).

In Canada, some employers choose to add enhanced benefits to a basic insurance plan for employees so that they may be covered by such complementary and alternative therapies as chiropractic, naturopathy, acupuncture, homeopathy, massage therapy and Christian Science healers (York University, 1999, 58). Some companies, like Husky Injection Moulding Systems Ltd. in Ontario, went so far as to employ an on-site naturopath. The employee insurance plan covered up to \$500.00 annually for chiropractic, off-site naturopathy and supplements. The company says that its absentee rate per year is 2.5 days a year versus an industry average of 6.5 days (York University, 61, 68-69). This may be due to increased staff appreciation and loyalty or actual measurable health improvements.

In Québec, the insurance plans of many public employees cover the services of naturopaths, chiropractors and other alternative professionals as well as the remedies they prescribe. Eight types of complementary and alternative medicine are covered by private insurance in Québec: chiropractic, osteopathy, naturopathy, acupuncture, kinesitherapy, homeopathy, phytotherapy and reflexology (York University, 1999, 72).

One of the issues for insurance companies is overuse of what, in effect, are wellness

techniques rather than cures for illness. Most insurance companies build in a ceiling above which the patient/client will not be reimbursed. Although doctors may object to private enterprise insuring unproven techniques, many insurance companies, after making sure that the practitioner has a licence to practice the alternative therapy (see York University, 1999, 73), seem content to pay for practices which appear not to harm. To confine insurable practices to those with a solid scientific base would be to exclude many currently privately insured practices. In the UK, insurance might reimburse only if a doctor has made the referral to an approved practitioner and only if the patient is diagnosed with a recognizable disorder (Fulder, 1996, 77). In this type of system, the doctor controls access.

Public Information

Another aspect of distributive justice is access to information. Prof. Marja Verhoef, of the University of Calgary, recommends a national resource centre for physicians and the general public. It would include data on the latest research, books, journals and websites (Verhoef, 1998, *Complementary Medicine: Impact on Physicians*, paper presented at Complementary Medicine in the Mainstream, Toronto, Ont., November 23, 1998). The organization proposed by Martel (see the last chapter) would also give members of the public information about alternative therapies. Martel recommends that the public be able to consult a list of therapists that includes their areas of specialty and their qualifications (Martel, 1992, 171). In fact, it would probably be helpful to create a directory similar to that which lists all physicians licenced to practice in a particular province. Guides are also available in bookstores. For example, Bonni L. Harden, a lawyer, and Craig R. Harden have produced *Alternative Health Care: the Canadian Directory -- your guide to finding qualified practitioners and educational programs* (1997). This directory lists therapies by type with sub-categories such as description of the therapy, its benefits, important questions for the consumer to ask, government regulations, Canadian and U.S. associations and

schools and the availability of each therapy in each province. Names and phone numbers are included.

Referral and information from one's physician is also an aspect of access which is why a central education information group is so crucial. Although authors, such as Michael Cohen, suggest that physicians might have a legal obligation to incorporate proven alternative therapies into their practices or to refer a patient to an alternative practitioner (Cohen, 1998, 59), most physicians have little knowledge of the field and are therefore in no position to make a referral. A government-funded information resource centre would be enormously helpful.

Commutative Justice

Commutative justice refers to fair exchanges between people. In the health care field it demands that professionals treat clients fairly, ensure that they give voluntary informed consent and offer goods in which the benefit is proportional to the risk. Most of these issues have been covered in the chapters on informed consent and on safety and efficacy.

Commutative justice also refers to the commercial aspects of medicine. The commercial exchange between practitioner and client should be just and fair, following the ethical standards of the marketplace. There should be no false advertising and no deception. A particular problem is the practice in which the person who prescribes the remedies then sells them. This practice is a conflict of interest, is coercive and manipulative and inherently deceptive in that the client may believe in the product because her practitioner sells it. Another ethical issue is the practice of homeopaths, who have obtained a licence to practice naturopathy, to falsely fill in an insurance form for naturopathic treatment when they have given homeopathic treatment. This is a fraudulent, but probably not uncommon, practice

meant to benefit those whose insurance companies will not pay for homeopathy.

Conclusion

Complementary medicine as a mainstream practice is in its infancy. To the extent that it is still, to many conventional physicians, alternative and unacceptable, regulations to govern it are unlikely to be as comprehensive as the mechanisms that control the practice of conventional medicine. Nonetheless, many associations of alternative practitioners already have codes of ethics and disciplinary systems in place. They need to be better publicized. Because so much of CAM is of unproven value, most therapies are unlikely to join the mainstream medical system as government- insured services unless they are practiced by physicians as a complement to conventional therapy. As long as CAMs remain in the commercial sphere, they can to some extent be controlled by commercial law. However, when a patient is a devotee of a religious healing movement, or participates in healing pilgrimages or rituals, ethical problems related to commutative justice may arise. Some of the problems are those inherent in a healing relationship in which the patient has a strong emotional bond with the movement or leader. Others, such as dangers of injury when being “slain in the spirit” (falling backwards under the presumed power of the Holy Spirit) or inhaling herbal substances in a First Nations sweatlodge, might be solved by a consent form. Some may find it ludicrous to demand that a ritual healer give participants consent forms but a student who participated in a sweatlodge thought she should have been warned of sinus problems following the inhaling of burnt herbs. Adults are presumed to freely choose their religious beliefs and they have the right of free association. Unless egregious harms are inflicted on members, such movements should probably be free of government control. However, if they advertise healing services to the public, they should provide information on possible harms. This is a vexatious question for some, who would like to see all so-called cults reined in by the law. The conclusion will examine a principle that can be

used for the ethical analysis of healing methods influenced by religion and spirituality.

Conclusion

This thesis has attempted to determine whether the principlist theory could be applied as readily to complementary and alternative medicine as to biomedicine. It has also asked if complementary and alternative medicine present ethical issues unique to the field.

Autonomy, non-maleficence, beneficence and justice are essential ethical precepts in which to ground *any* healing practice, but some of the issues discussed in sections three and four do not appear to be easily settled by an application of the four principles. I conclude that these four principles are necessary, but not sufficient, to guide the practice of complementary and alternative medicine and that three issues are unique to the field, the third particularly so. The issues are:

- 1. Safety and efficacy, serious concerns of conventional medicine, are very much in question in the field of complementary and alternative medicine. Research is essential, particularly in the field of herbal remedies, if the safety and well-being of the public are to be protected.**
- 2. Complementary and alternative medicine is not accountable in the same way that conventional medicine is and its standards of training are inconsistent. While alternatives will probably always exist, appealing to the antinomian instincts of those who reject all official control, the public would benefit from a government-led system of training, regulation and licencing of alternative practitioners.**
- 3. The religious and spiritual elements of complementary and alternative medicine are hard to avoid and even harder to submit to ethical scrutiny. While the four principles can be applied to spiritual forms of healing, they may not be sufficient.**

Do these issues require an extension of the four-principles theory? Do the principles have sufficient output power (see Beauchamp and Childress, 1994, 45-47) to form the basis of an ethical theory that is large enough to incorporate the three issues?

Insofar as an alternative practice is similar to a conventional medical practice, the four principles theory is probably adequate. Beauchamp and Childress themselves pointed out that the system was sufficiently comprehensive for biomedical ethics but not for normative ethics (Beauchamp and Childress, 46). Therefore, insofar as a practice is structurally like medicine, the four principles are easy to apply. Even when the practice is not similar to conventional medicine, issues of safety, accountability and training, so significant in this field, are addressed by the principles of non-maleficence and beneficence. Some believe that accountability, an issue of enormous importance in complementary and alternative medicine, requires different ethical principles such as promise-keeping or truth-telling. I would subsume these under the general categories of beneficence and non-maleficence.

Part of this thesis has focused on the religious and spiritual influences on complementary and alternative medicine. It is this aspect, I believe, that cannot easily be made to fit the tidy categories of the four principles.

Leaders of religious or spiritual healing groups, as well as those who practice spiritual-type healing, may argue that their methods are immune to ethical analysis. Clients or devotees of such groups or practices are unlikely, if drawn by strong spiritual impulses, to rigorously question the healer's respect for their autonomy or concern for their well-being.

Those who practice or seek out religious forms of healing may, in fact, resent attempts to impose standards of disclosure and consent that were developed to protect the users of

biomedicine. It is absurd to envisage the leader of a charismatic healing group proffering a detailed list of the risks and benefits of the laying-on-of-hands. But is it such a stretch to ask that those who advertise healing services in newspapers (in other words, attracting the general public, not church members) require all prospective participants to sign a form attesting to the fact that they know what they are undertaking? Concerns about legal liability may already have persuaded some healing group leaders to do just that.

Although signing a form is not proof that the client fully understands risks and benefits, it serves as a reminder that a procedure may carry risks and at least asks potential clients to stop and consider what it is they are about to do. However, those who seek religious healing are hardly likely to be discouraged by the requirement to sign a consent form. When need is great and emotions are high, such acts can seem like mere formalities. To some extent, the same is true in biomedicine. Informed consent is so very much more than an act of pure reason. The desire to be healed is rooted at an emotional depth that may be impervious to any extrinsic legal requirements.

Religious and spiritual healing practices are always proposed as beneficent acts. If a healing group is part of an organized religion, officials, such as moderators or bishops, may act to prevent leaders from harming devotees. But spiritual healers, caught up in a belief in the essential “rightness” of their mission, may find it difficult to question their own motives. Self-deception can abound in this field. A discussion of religious cults lies outside the scope of this thesis but it is not difficult to see how a charismatic leader could convince himself and his followers that any pain suffered is part of spiritual growth, or evidence that the former sinner is being “tried” in a metaphorical cleansing fire. Leaders and devotees are easily bound up in a mutual, if destructive, belief that suffering is either imposed from outside (from relatives of devotees or concerned government groups) or is a necessary part

of the healing process.

The majority of healing groups do not fall into this category but elements of manipulation, self-deception and coercion mean that followers of some groups are subtly controlled in such a way that their autonomous will is impaired. Thus, the spiritual and religious components of CAMs do raise new ethical challenges. These elements are not easily contained within the biomedical ethical model which was created in response to the increasing capacity of modern technological medicine to harm physically, not emotionally or spiritually. Alternative forms of healing have more in common with old-style beneficent paternalism, with all its inherent dangers. Healers who model themselves on professional groups are most likely to welcome the apparatus of modern medical practice: licencing, codes of ethics, training standards. Spiritual healers have more in common with priests and shamans than with scientific physicians. To the extent that a practitioner operates from a spiritual base one must look beyond the four principles to see if another ethical principle is salient.

Margaret Battin addresses this very issue in *Ethics in the Sanctuary*. Many believe, she says, that ethics is derived from religion and therefore cannot itself be used to analyze religious practices (Battin, 1990, 2). Of the three issues Battin regards as central -- confidentiality, risk-taking and convert seeking (Battin, 3-4) -- this thesis has dealt only with risk-taking.

Battin's approach is to use the standards of secular ethics as a lens through which to view religious practice and to discern problems that might otherwise go undetected (see Battin, 1990, 7). According to Battin, some faith healing groups use doctrine itself to violate autonomy by shunning or excommunicating those who seek medical attention outside the

group. This coercive threat serves to reduce choice. On the other hand, a counter argument Battin makes is that granting people autonomy also grants them the right to take risks in accordance with their chosen beliefs. Such issues are particularly troublesome for society when the risk-taking behaviour of the member of a religious group leads to the death of a child. Frequently, the law condemns those who expose children to avoidable risk or death (Battin, 77, 82, 90, 84, 85)

Battin argues that “self-harming choices ought not to be honored where emotion is heightened, at least not if it is so heightened as to impair the capacity for autonomous choice” (Battin, 1990, 92). She argues for “paternalistic intervention” while recognizing that many decisions are made under the influence of strong feeling (Battin, 92), for example, proposals of marriage.

Battin points out that what we identify as abuses from the standpoint of ethical analysis (coercion, manipulation and deception) are not necessarily abusive when they occur in religious groups (Battin, 1990, 115). But, she says, it is obvious that these may violate the requirement for informed consent and asks if “paternalistic, harm-based exceptions to the principle are legitimate” (Battin, 116).

To take this into account, rather than readily condemning a practice on the grounds that it violates autonomy, Battin supplements her ethical analysis with the fiduciary principle which is distinct from, and cannot be reduced to, autonomy, non-maleficence or beneficence. This is the principle that defines the obligations of professionals to clients and is used in professional contexts (Battin, 1990, 117).

This principle seems to offer a way out of the quagmire that results when one tries to apply

the four-principles theory to spiritual healing groups. It might also be useful when analyzing any type of healing practice with a spiritual component. The greater the spiritual or religious content of a practice, the more likely it is that the individual's autonomy is compromised. Yet to say that this must be avoided is to imply that religious beliefs and practices are an assault on autonomy. To some extent, all brought up devoutly in a specific faith may be quite unable to leave it as they firmly believe that eternal salvation depends on adherence. Yet one cannot accuse all rabbis, Catholic priests or evangelical ministers of seeking power through brain-washing (though some do so). The principle of autonomy is too restricted an ethical theory in this context. The fiduciary principle offers a way out.

The fiduciary principle demands that the professional act in a way so as to inspire trust and actively avoid abusing that trust. Though the fiduciary principle, Battin says, "may seem similar to the more general principle of nonmaleficence", it is far less general and recognizes the inherent imbalance of power in most professional relationships. It also goes further than the principle of autonomy because it insists that the professional makes sure that she serves the client's interests. The fiduciary principle is a principle of loyalty. As Battin says, all the elements of autonomy can be "derived from it" (Battin, 1990, 118). The fiduciary principle prohibits the professional from violating moral principles in such a way as to undermine those aims or interests for which a client seeks protection or advancement in using the professional's services (Battin, 121). It does not help work out the conflicts between principles of autonomy, non-maleficence and beneficence, but it does demand that when an individual seeks out a spiritual healer, he should be assured that:

the developed practices, doctrines, methods, and teachings employed by religious professionals or their religious organizations must meet (secular) ethical criteria wherever the individual participates in these practices to advance his or her self interests (Battin, 1990, 122).

This principle, she says, works as a second principle, supplementing the others, and is limited to religious practices (Battin, 1990, 122).

The relevant point is that the religious professional is offering a service and the fact that he or she is religious does not make him immune from the moral norms of secular professions. The example she uses is that of the Christian Scientist who goes to a Christian Science healer for health problems. This person, even though a member of the church, is a client of a healer whose services may be reimbursed by insurance and is therefore in a different situation from the person approaching a church official to deepen faith (Battin, 1990, 122-123). This moves healing into the secular realm and focuses on what it is the client seeks (see Battin, 124). A religious group that tells the general public that it can satisfy specific interests such as healing is therefore governed by the fiduciary principle. The healing professional must therefore take a particular stance:

In religion, since the fiduciary principle underwrites the application of standard ethical principles -- autonomy, nonmaleficence, beneficence, and justice -- when adherents approach with self-interested aims, it thus also underwrites the application of these principles when the religious group and its officials announce themselves as available to help persons pursue their interests (Battin, 1990, 124).

When a religious or spiritual group opens its practices to the public, it comes under secular standards governing the means it uses to serve the interests of the seeker. Battin notes that some clergy now purchase malpractice insurance when engaged in professional practices like counselling but not for the performance of rituals (Battin, 1990, 124). If a spiritual or religious group advertises healing practices (as some New Age religious groups do) then they offer a clear-cut service that is governed by the fiduciary principle. Faith healing and charismatic masses, insofar as they are rituals but not professional practices, seem to occupy a grey area. But, to the extent that they advertise in newspapers, they are offering a service to the public and the fiduciary principle applies.

Battin realizes that one may not be able to formulate a policy to govern all religious activities and practice but it is important to distinguish those aspects of religious practice that can suitably be analyzed according to the fiduciary principle from those that cannot (Battin, 1990, 126).

The fiduciary principle demands that the professional be loyal and not take advantage of her client (Battin, 1990, 127). This principle is a useful tool but will scarcely make a dent in the hubris of some healers who are convinced of the unassailability of their position.

According to Battin, all professional groups have what she calls stock issues which are related to the structure all professional groups have in common. Confidentiality is a stock issue. Counterpart issues, she says, are those in which religious groups and professional groups share issues that are similar but not as close as stock issues. The way in which informed consent is understood in medicine versus the way it is understood in healing groups is one example. In conventional and many types of complementary and alternative medicine, the decision made by the patient/client is an individual one. In healing groups, members may all make similar choices. She suggests that it might be useful to see if within one profession -- medicine -- different groups of patients and different groups of medical specialists tend to understand informed consent in the same way (Battin, 1990, 256-259). For example, do surgeons influence high risk-taking behaviour and internal medical specialists lower? Would the clients of an oncologist take more risks than the clients of a naturopath? Analyzing issues in one field can bear fruit in another.

Some issues are unique to religion and do not have counterparts in other professions.

Battin uses baptism as an example. Professional ethics may be able to identify problems but

it cannot understand or get to the heart of the issue (Battin, 1990, 259-262). Battin suggests that, in analyzing spiritual ethical issues, that one begin with the stock issues, "then move to the counterpart issues, and save the unique issues, if one has courage for them at all, until last" (Battin, 262).

Unique issues in religious groups may help highlight issues that may be disregarded in secular professions. (Battin, 1990, 262). The same is true in analyzing unique issues in complementary and alternative medicine. For example, serious attention to the risks of complementary and alternative medicine reveals that standard medicine can pose enormous risks, many of which are assumed by doctor and patient not to be worthy of comment. Psychiatry is the most obvious parallel to healing groups in religion. The mechanism of transference, in which the patient attaches to and projects onto the psychiatrist feelings that reach as far back as the mother-infant bond, is assumed to be part of the healing process. But it can be inordinately damaging, rendering the patient unable to criticize or leave the therapist. The fiduciary principle is very much relevant here but to what extent do psychiatrists warn their patients of such debilitating attachments?¹¹¹

Battin argues for the moral force of ethical scrutiny, not state power, when critiquing religious practices (Battin, 1990, 269). In terms of regulating the entire field of complementary and alternative medicine, a mix of the two is probably needed. In issues of safety and accountability, government controls need to be in place as the threat of harm is clear. Where religious and spiritual elements pose a risk of depriving individuals of their freedom, state control would likely be futile. This is where Battin's application of the

¹¹¹On a related note, the patient going into surgery has (or should have) been told of the risks of surgery. But the risks of iatrogenic (doctor-caused) illness or nosocomial (hospital-caused) infections are often simply assumed.

fiduciary principle is most useful.

The challenge facing the ethicist of the future will be to find a way of honouring the specific values of complementary and alternative medicine as it moves closer to the medical mainstream. If alternative practices are to be conducted in hospitals, all relevant professional ethical standards will have to be applied, but in such a way that those who apply them acknowledge the uniqueness of what will still, probably, be seen as alternative practices. If a practitioner who believes in channeling supernatural healing spirits is to practice in a hospital, this must be disclosed to the person doing the hiring and to the patient. The hospital or unit administrator may decide that such a practice is harmful and deny employment.¹¹² But if individual patients want a spiritual healer at their bedside, justice might demand that medical staff are to permit it. In many cases, the visit of a healer is accepted but the patient is privately mocked. As more and more patients become aware of the possibilities inherent in alternative methods, the practice of insisting that the doctor is the final arbiter of who gets to treat the patient may be modified to accommodate practitioners who will be genuinely complementary. This is a contentious area as the treating physician needs to be aware of any treatments her patient is receiving to avoid the dangers of drugs interacting with herbs or the possibility of guided visualization altering the effect of a medication as described in chapter eight. Until doctors are trained in and encouraged to be respectful of alternative practices, patients will continue to be at risk if they combine conventional medical treatment with ones that are unauthorized by and unknown to the

¹¹²This points out a problem between conventional religion and what, for want of a better phrase, we could call alternative religion. No hospital administrator, physician or nurse finds it odd when a Catholic festoons his bed with holy pictures, medals and crucifixes. They are culturally recognized amulets. But some express anxiety when faced with spiritual practices that seem, to the conventional Christian, Muslim or Jew, to be either bizarre or dangerously pagan. The point is, it is up to the patient to decide what is spiritually helpful. Incidentally, I am not criticizing Catholic ritual, merely pointing out phenomenological similarities between diverse practices.

physician. Some hospitals say that this is a particular issue when ethnic groups bring in their traditional healers and they have tried to develop policies to guide communication between the two groups (personal communication with hospital administrators, conference, Toronto, Ont., October 1998).

For relatively healthy people consulting individual practitioners, the best protection is knowledge. Both doctors and the public need more information on what complementary and alternative medicine can do, on how to choose a reputable practitioner and how to assess products. Alternative medicine may never, and perhaps should never, fully enter the mainstream. Individuals need choice and should be able to go outside the state-funded system for a healing practice that appeals. But physicians need to understand far more about complementary and alternative medicine than is currently the case. It is not their job to instruct their patients on what alternative practices they will permit, but it is their job to know as much as they can so that they can understand what their patients want and need and thus be able to offer informed advice when asked.

Ethicists might want to join with the federal and provincial governments to design policies monitoring this field. But in the unique aspect of complementary and alternative medicine -- its religious and spiritual elements -- they will need to collaborate with religious professionals so as to fully understand those areas where they might be neither welcome nor needed.

Not all of life needs to be legislated but some practices need to be regulated. Ultimately the public is best served by guarantees that practices and products are safe and professionals trained and accountable. Individuals should be free to ignore government warnings if they wish and go to whatever sort of healer they prefer, even if that person, whether a religious

healer or not, is unlicensed and unregulated. But they should know who is professionally accountable and who is not. Practitioners need to be made aware of those practices that could be construed as coercive. Just as medical doctors often believe so deeply in a proposed cure that they persuade or even bully patients, so too can alternative healers engage in excessively paternalistic behaviour. Beneficence is a laudable motive but it can translate to a maleficent attenuation of autonomy. If justice is to be served, complementary and alternative medicine needs to be taken seriously as a valid consumer choice, governed by ethical principles that ensure that the public is not penalized by choosing an alternative over a conventional therapy.

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